

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08284

CERTIFICATE OF DEATH

08272

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville - 6502 - 8th Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colonial Villa Nursing Home</b>		d. STREET ADDRESS <b>12325 New Hampshire Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Peter Adamson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-92</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bur. of Engr.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Adamson</b>		14. MOTHER'S MAIDEN NAME <b>Rose Maux</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>340-037-4027</b>	
17. INFORMANT <b>Mrs. Lorraine A. Miller (above)</b>		Address <b>(above)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341</b> DUE TO <b>Acute heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHF</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6-12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CVA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-25</b> , 1967, to <b>6-12</b> , 1967, that (I) (we) last saw the deceased alive on <b>6-6</b> , 1967, and that death occurred at <b>5:22</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>R. H. Sandstrom</b>		22b. DATE SIGNED <b>6-12-17</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstrom MD</b>		22d. ADDRESS <b>7701 Carroll Ave Takoma Park, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

JUN 16 1967

2520



TABLE 1. Continued

08285

## CERTIFICATE OF DEATH

08274

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN Tb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>766 Fairview Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Algert</b> Middle <b>Daniel</b> Last <b>ALEXIS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 67</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1897</b>		
				9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy/Engineering Consultant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Minersville, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Alexis</b>				14. MOTHER'S MAIDEN NAME <b>Helen Kell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes -1954</b>		16. SOCIAL SECURITY NO. <b>085-30-7020</b>		17. INFORMANT <b>Annapolis</b> Address <b>Maryland</b> <b>Mrs. Mabel Glenn Alexis, 766 Fairview Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>150X</b> DUE TO <b>REOCURRENCE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Reurrence and Metastasis of Carcinoma of the</b> DUE TO <b>Esophagus</b> (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 7, 1967</b> , to <b>June 12, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 12, 1967</b> , and that death occurred at <b>8:10AM</b> , from causes on and on the date stated above.								
22a. SIGNATURE <b>Perry Ah-Tye</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12 June 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Perry Ah-Tye. M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers 8655 Georgia Ave. Silver Spring, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUN 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #2c & d Film #G390 6/27/67 pc									
08286 CERTIFICATE OF DEATH 08275									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN lb <b>13 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY District Heights, Md. 162</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County Gen. Hospital</b>					d. STREET ADDRESS <b>BROOKE GROVE FOUNDATION</b> <b>BROOKE GROVE RD. St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN A. AMOS</b>					4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>19 67</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-13-01</b>		9. AGE (In years last birthday) <b>65 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BUS DRIVER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN C. AMOS</b>					14. MOTHER'S MAIDEN NAME <b>Not Known</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-10-8400</b>		17. INFORMANT <b>MEDICAL RECORD DEPT.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exanguination</b> DUE TO (b) <b>Bleeding duodenal ulcer</b> DUE TO (c) <b>Peptic ulcer, duodenum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>June 6, 1967</b> to <b>June 9, 1967</b> , that (1) (we) last saw the deceased alive on <b>June 8, 1967</b> , and that death occurred at <b>3:00 P.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>John R. Spencer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-9-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN R. SPENCER, M. D.</b>					22d. ADDRESS <b>15444 COLUMBIA PIKE, BURTONSVILLE, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>6/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons. 300 4th St. NEWash. DC</b>					25a. RECEIVED BY REGISTRAR <b>JUN 14 1967</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>		

02512

CHURCH OF ENGLAND



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08287		08276	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>9514 Tuckerman St</b> b. COUNTY <b>Pro Geo County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>		d. STREET ADDRESS <b>9514 Tuckerman street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA O. ANDERSON</b>		4. DATE OF DEATH Month Day Year <b>JUNE 12, 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 27, 1874</b>
9. AGE (In years last birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Esther Mathey Seabrook, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>lost.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>chronic bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 1966, to <b>6/12</b> , 1967, that (I) (we) last saw the deceased alive on <b>6/12</b> , 1967, and that death occurred at <b>2 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>6/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. F. Kreuzburg</b>		22d. ADDRESS <b>7832 16th Ave Los Angeles 20012</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>N Hollywood Los Angeles Cal.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>John 15 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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Cleared with Medical Examiner - *MS*

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08288

08277

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>11500 Amherst Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE Caparotti Anderson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Separated</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/7/17</u>		9. AGE (In years last birthday) yrs. <u>49</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fort Worth, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Augustus G. Rintleman</u>				14. MOTHER'S MAIDEN NAME <u>Edna B. <del>Caparotti</del> Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-12-3072</u>		17. INFORMANT <u>Ralph B. Caparotti - (Son)</u> Address <u>2366 Glenmont Circle, Wheaton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Miscellaneous Infection</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Enteric and Heat Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs -</u> <u>- 5 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962 to present</u> , 19 <u>62</u> to <u>present</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>George Sharpe</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				22d. ADDRESS <u>10400 Conn. Ave., Kensington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>June 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>65 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>2811 Seidenberg Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Anheir</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1893</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>257 22 9227</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY ABSCESS AND PULMONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MASSIVE GASTRO-INTESTINAL HEMORRHAGE</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 23</b> , 19 <b>67</b> , to <b>June 27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 27</b> , 19 <b>67</b> , and that death occurred at <b>340PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Francis C. Johnson</i>		22b. DATE SIGNED <b>June 28, 1967</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>FRANCIS C. JOHNSON M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-29-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Key West City Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Key West Florida</b>
24. FUNERAL DIRECTOR <b>Jos. Gawler &amp; Sons</b> <b>5130 Wisconsin Ave., N. W. Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>JUN 30 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>CHEVY CHASE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL</b>		d. STREET ADDRESS <b>7605 MEADOW LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ARMSTRONG</b> Last <b>ARMSTRONG</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 25 1886</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>80 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN MEDICAL DIRECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NIH</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ALLIANCE, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THEODORE ARMSTRONG</b>		14. MOTHER'S MAIDEN NAME <b>EMMA BERTOLETTE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes CG 1910-1919</b>		16. SOCIAL SECURITY NO. <b>220 44 5568</b>	
17. INFORMANT <b>MARY E ARMSTRONG</b>		Address <b>7605 MEADOW LANE CHEVY CHAS MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>6000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Chronic Pyelonephritis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6000</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 20</b> , 19 <b>67</b> , to <b>JUNE 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 22</b> , 19 <b>67</b> , and that death occurred at <b>12:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>F. H. O'CONNELL</b>		22b. DATE SIGNED <b>JUNE 22 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL</b>		22d. ADDRESS <b>US NAVAL HOSPITAL BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Type) <b>REMOVAL</b>		23b. DATE THEREOF <b>26 Jun 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SENECAVILLE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SENECAVILLE, OHIO</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>Wash, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		DATE <b>JUN 29 1967</b>	

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN Tb <u>79 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. + HOSPITAL</u>		d. STREET ADDRESS <u>25 E. WAYNE AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>Emily</u> Middle <u>XXXXXXXXXX</u> Last <u>ARNOLD</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/90</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM ARNOLD</u>		14. MOTHER'S MAIDEN NAME <u>MISSOURI MELSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-46-6123</u>	
17. INFORMANT <u>William Haythe</u> <u>HOSPITAL</u>		Address <u>9909 Woodburner Rd</u> <u>Silver Spring, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Basal Cell Carcinoma of Face, Cirrhosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Several Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>67</u> , to <u>6-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-23</u> , 19 <u>67</u> , and that death occurred at <u>2:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>6-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>831 Univ. E., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 26, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D C</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JUN 28 1967</u>	
ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE	

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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 104

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD.# 3 Gaithersburg</b>				d. STREET ADDRESS <b>RFD # 3 Gaithersburg</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS H. ATHEY, Sr.</b>		First Middle Last		4. DATE OF DEATH <b>June 10, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/95</b>		9. AGE (In years lost birthday) yrs. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John S. Athey</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-30-4170-A</b>		17. INFORMANT <b>Willie B. Athey-Item# 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>2-3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>58</b> , to <b>10 June</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>20 June</b> , 19 <b>67</b> , and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. S. Murphy</b>		22b. DATE SIGNED <b>6/12/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. S. Murphy</b>	
22d. ADDRESS <b>Rockville, Maryland</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Church Cem. Darnestown, Md.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>		23e. REC'D BY REGISTRAR <b>15 1967</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08293

08282

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>MARYLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Box 33</b>			
3. NAME OF DECEASED (Type or print) First <b>Alfreda</b> Middle <b>Elaine</b> Last <b>Austin</b>				4. DATE OF DEATH Month <b>6</b> Day <b>11</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-26-65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		9. AGE (In years last birthday) <b>2 yrs.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>James Hill</b>				14. MOTHER'S MAIDEN NAME <b>Frances Austin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Medical Records, Montg. General Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5</b> <b>Plumhoff - Congestive heart failure</b> DUE TO (b) <b>Congenital heart defect</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>2 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John B. Ball</b>		EXAMINER'S NAME (Type) <b>John B. Ball</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ASH MEMORIAL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>SANDY SPRING, MONTG., MD.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>ROCKVILLE, MD.</b>		25a. REC'D BY REGISTRAR <b>JUN 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08294

CERTIFICATE OF DEATH

08288

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Boyd</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Boyds</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		d. STREET ADDRESS <i>Route 1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edith First Gertrude Last Austin</i>		4. DATE OF DEATH <i>June 21 1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 18, 1896</i>
9. AGE (in years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months <i>9</i> Days <i>3</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Postal mistress</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Ri, Boyds, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James H Austin</i>		14. MOTHER'S MAIDEN NAME <i>Rhoda Ann Stewart</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>225-60-1023</i>	
17. INFORMANT <i>John H. Austin,</i>		Address <i>Boyd, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>exhaustion</i> 794X DUE TO (b) <i>Senile debility</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>senile changes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan - 1 - 1963</i> , to <i>June - 21 - 1967</i> , that (I) (we) last saw the deceased alive on <i>June - 18 - 1967</i> , and that death occurred at <i>6:30 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller, M.D.</i>		22b. DATE SIGNED <i>6-21-1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d. ADDRESS <i>7 Brooke Ave, Gaithersburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6-24-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	23d. LOCATION (City or Town) (County) (State) <i>Barnesville montg Md</i>
24. FUNERAL DIRECTOR <i>Ernest G. Gartner</i>		ADDRESS <i>Gaithersburg. Md.</i>	
25a. REC'D BY REGISTRAR <i>JAMES JUDGE</i>		25b. REGISTRAR'S SIGNATURE <i>JAMES JUDGE</i>	
DATE <i>JUN 26 1967</i>			

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General</b>		d. STREET ADDRESS <b>19 Cedar Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Brook</b> Last <b>Austin</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-83</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>24 19 67</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Mahlon Austin</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rawlins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-10-0278</b>	
17. INFORMANT (Daughter) <b>Mrs. Erances A. Peyton-7807 Brickyard Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with Congestive Heart Failure</b> DUE TO (b) <b>Heart Failure</b> DUE TO (c) <b>terminal event</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertrophy of Prostate Gland</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1967</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>6-20-67</b> to <b>6-24-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6/23 1967</b> , and that death occurred <b>10:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b>		22b. DATE SIGNED <b>6-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>		22d. ADDRESS <b>Gaithersburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/27/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethesda, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUN 27 1967</b>	
ADDRESS <b>1331 Rockville Pike Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN b. <b>18 days / 13 1/2 hrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
3. NAME OF DECEASED (Type or print) <b>Edward John Bannon</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1893</b>
9. AGE (In years last birthday) <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Structural Steel Worker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon Bannon</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Devens</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-803-5164</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>7600 Carroll Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Renal Dehilitation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>from Carcinoma of the Lung</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1967, to <b>June 7</b> , 1967, that (I) (we) last saw the deceased alive on <b>June 6</b> , 1967, and that death occurred at <b>4 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>R. C. Bufalino</b>		22b. DATE SIGNED <b>June 7, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Russell C Bufalino, M.D.</b>		22d. ADDRESS <b>1429 University Blvd W. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10 JUNE 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	23d. LOCATION (City or Town) <b>SILVER SPRING MD.</b> (County) _____ (State) _____
24. FUNERAL DIRECTOR <b>RINALDI FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>June 9 1967</b>	
ADDRESS <b>1100 GA. AVE. NW</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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08297

CERTIFICATE OF DEATH

08286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1-year</u>		d. STREET ADDRESS <u>10901-Amherst Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10901-Amherst Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAX BARACK</u>		4. DATE OF DEATH <u>June 5 - 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-90</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes, Unknown</u>	
17. INFORMANT <u>Mr. Sadie Barack</u>		Address <u>10901-Amherst Ave. S.S. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1965</u> , to <u>6-1-1967</u> , that (I) (we) last saw the deceased alive on <u>6-1-1967</u> , and that death occurred at <u>11:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>6-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry M.D.</u>		22d. ADDRESS <u>11602 Georgia Ave. S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Math. Mom. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church Virginia</u>
24. FUNERAL DIRECTOR <u>Soldberg Funeral Home 4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 6 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		d. STREET ADDRESS <i>3215 University Blvd., W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>IDA ANTOINETTE BEALE</i>		First <i>IDA</i>		Middle <i>ANTOINETTE</i>		Last <i>BEALE</i>		4. DATE OF DEATH Month <i>JUNE</i>		Day <i>7</i>		Year <i>1967</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 17, 1882</i>		9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>Francis P. Holmes</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle Kelser</i>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Francis G. Read</i>		Address <i>2101 Parker Avenue Silver Spring, Maryland</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 CONGESTIVE HEART FAILURE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 WEEKS</i> <i>15 YEARS</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>JULY 1967</i>		(County) <i>WASHINGTON D.C.</i>		(State) <i>20012</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>JULY 1967</i> to <i>JUNE 7, 1967</i> , that (I) (we) last saw the deceased alive on <i>JUNE 5, 1967</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>Robert L. Krichmar</i>		M.D. <i>ROBERT L. KRICHMAR</i>		22b. DATE SIGNED <i>JUNE 7 1967</i>		22c. PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR</i>		22d. ADDRESS <i>7733 ALASKA AVENUE N.W. WASHINGTON D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 9, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cemetery</i>		23d. LOCATION (City, town or county) <i>Arlington, Virginia</i>									
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25. REC'D BY REGISTRAR <i>JUN 12 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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08288

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY in 1b <b>month</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Derwood</b>		d. STREET ADDRESS <b>15-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sylvan Manor Health Care Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Bell</b> Last <b>BEALL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/1900</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mont. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Coleman</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Butt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Rowland O. Beall 602 Monroe St. Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoprotecemia</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic Debilitation</b> (c) <b>Carcinomatosis - Origin Undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>MD.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> e.m. <b>30</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1967</b> to <b>June 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1967</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Thibadeau</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT V. THIBADEAU</b>				22d. ADDRESS <b>ROCKVILLE MD 20852</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-19-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 20 1967</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Yvonne Manor Health Care Center

Minnie Bell

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Home

H. Wife

Nettie

William H. Coleman

Rowland O. Seal

002 Monroe St.

Rockville, Md.

Rockville Union

6-19-77

Barrel

Laurensville, Md.

Francis H. Barber

Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08300

CERTIFICATE OF DEATH

08289

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colonial Villa-12325 New Hampshire Ave,</b>				d. STREET ADDRESS <b>1206 Parker Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Julian F. Belfield</b>				4. DATE OF DEATH Month Day Year <b>6 11 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-85</b>	
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Westmorland Co., Va..</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S..</b>			
13. FATHER'S NAME <b>LeRoy Belfield</b>				14. MOTHER'S MAIDEN NAME <b>Mary Spillman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-52-6674</b>		17. INFORMANT Address <b>Mrs. Julian Belfield, 1206 Parker Ave., Hyattsville, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4021 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> , 19 <b>67</b> , to <b>6-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-11</b> , 19 <b>67</b> , and that death occurred at <b>2:40</b> PM, from causes and on the date stated above.							
22a. SIGNATURE <b>Eino Maki</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-11-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAKI</b>				22d. ADDRESS <b>831 University Blvd. E. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons. 300 4th St. NE. Wash., DC</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08301

CERTIFICATE OF DEATH

08290

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Springfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>7032 Beverly Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Catherine</b> Middle <b>Regina</b> Last <b>BENNER</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> 18 Day <b>19</b> Year <b>67</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Cauc</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec. 14, 1919</b>
<b>9. AGE</b> (In years last birthday) yrs. <b>47</b>		<b>10. IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Intelligence Analyst</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Wilkes Barre, Penn.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward R. McNamara</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen M. Dunphy</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>124-18-5442</b>	
<b>17. INFORMANT</b> <b>Springfield</b> Address <b>Virginia</b> <b>Mr. Bruce K. Benner, 7032 Beverly Lane</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>intra cranial &amp; hepatic metastases</b> <b>1527</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>jejunal carcinoma</b> DUE TO (c) <b>3 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (b) (this hospital) attended the deceased from <u>May 9, 1967</u> to <u>June 18, 1967</u>, that (i) (we) last saw the deceased alive on <u>June 18, 1967</u>, and that death occurred at <u>1255P</u> M, from causes on and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Evans Diamond, M.D.</b>		<b>22b. DATE SIGNED</b> <b>June 19, 1967</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Evans Diamond, M. D.</b>		<b>22d. ADDRESS</b> <b>Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>June 21, 1967</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's Cemetery</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Wilkes Barre, Pennsylvania</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Robert J. Murphy</b> ADDRESS <b>Funeral Home, 3524 Columbia Pike, Arlington, Va.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 21 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

1029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08302

CERTIFICATE OF DEATH

08291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>4 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47.3</u> d. STREET ADDRESS <u>200 16th St., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mamie Doss BENNETT</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 5, 1865</u>	
9. AGE (In years last birthday) <u>101</u> yrs.		IF UNDER 1 YEAR Months <u>101</u> Days <u>101</u> Hours <u>101</u> Min. <u>101</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Resident Manager</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida County, Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>218-24-2386</u>		17. INFORMANT <u>Mrs. Dorothy Smith</u>		Address <u>Rt. 4, Box 153A Culpeper, Virginia</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Old Age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4341</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-20</u> , 19 <u>67</u> , to <u>6-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>67</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Thibadeau</u>				M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>ROCKVILLE 20852</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>June 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newbern Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Newbern, Alabama</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 22 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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RECORD OF DEATH

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RECORD OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08303

08292

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH. SAN. AND HOSPITAL</b>				d. STREET ADDRESS <b>7520 MAPLE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Valentine Berberich</b> First Middle Last				4. DATE OF DEATH <b>JUNE 15 1967</b> Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-24-99</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - ACCOUNTANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>I Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. AMERICAN</b>							
13. FATHER'S NAME <b>John V. Berberich, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Prachter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-44-2868</b>		17. INFORMANT <b>PTS C HART</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>4201</b> (b) <b>A.S.H.D.</b> DUE TO <b>Generalized A.S. obliteration</b> (c) <b>Diabetes</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 M.I.'s in the past Hypoalbuminemia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>NEURITIS</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>67</b> , to <b>6/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/15</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>K. Cruse</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>D.R.K. CRUSE</b>				22d. ADDRESS <b>831 UNIVERSITY BLVD. F. SILVER SPRING, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-17-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>				25a. REC'D BY REGISTRAR <b>JUN 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF TEXAS

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THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County.

WITNESSED my hand and the seal of the County at Dallas, Texas, this 10th day of May, 1900.

CLERK OF THE COUNTY

My commission expires the 10th day of May, 1901.

ATTEST:

Notary Public for the State of Texas

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

My commission expires the 10th day of May, 1901.

NOTARY PUBLIC

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G390 6/29/67 pc

08304

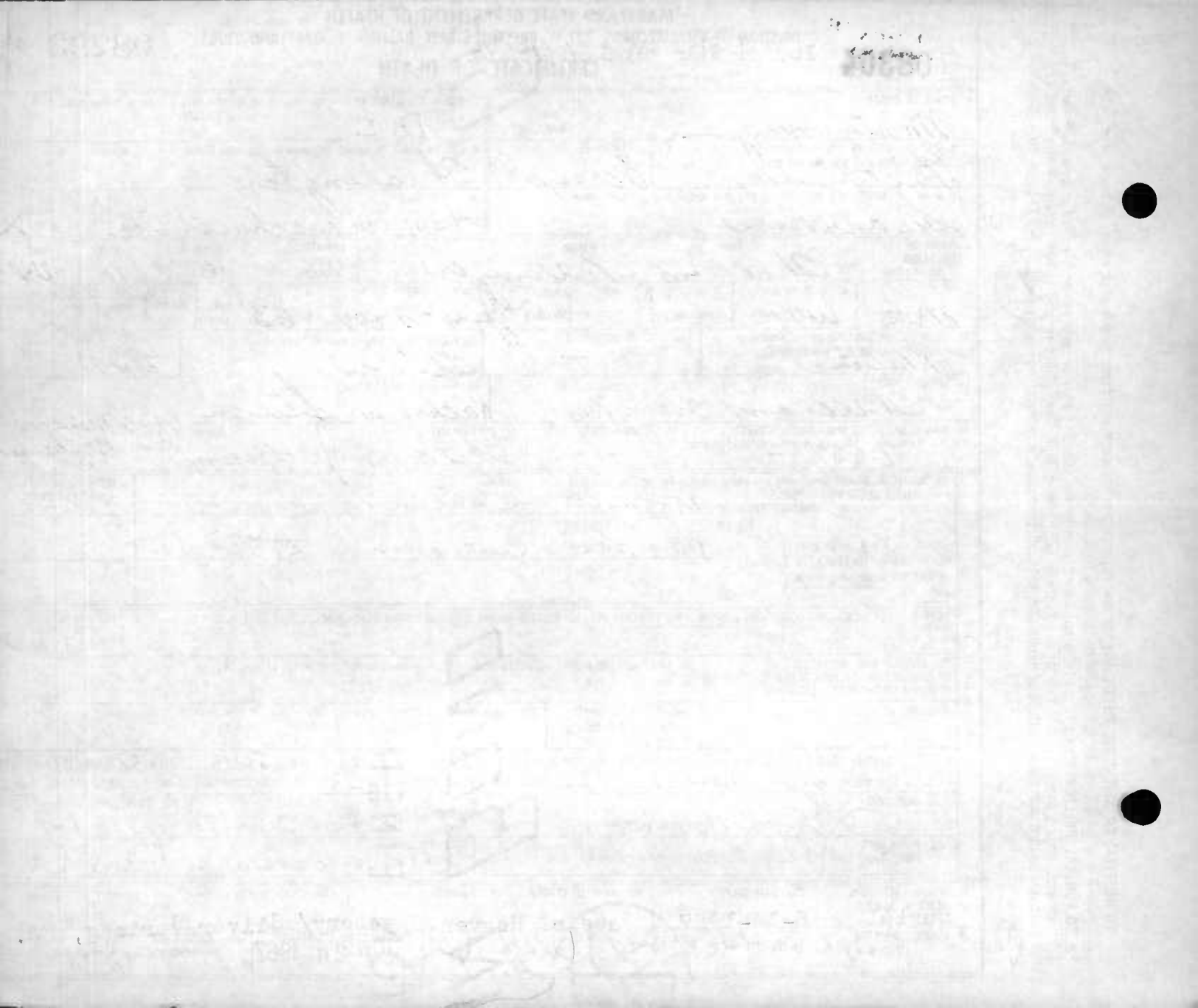
CERTIFICATE OF DEATH

08293

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>4301 Massachusetts Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Beringer</u> First Middle Last		4. DATE OF DEATH <u>6 - 11 - 1967</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1904</u> 63 yrs.
9. AGE (In years last birthday) <u>63</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Beringer</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Stark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>William J. Beringer</u> Address <u>6403 Madison Lane Bethesda Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA RECTUM</u> <u>1550</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PRIMARY CARCINOMA LIVER</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>52</u> , to <u>JUNE</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 11</u> 19 <u>67</u> , and that death occurred at <u>930</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DR LEO I DONOVAN</u> M.D.		22b. DATE SIGNED <u>6/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR LEO I DONOVAN</u>		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-14-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery / Silver Springs, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Cawlers &amp; Sons</u> ADDRESS <u>Washington D.C.</u>		25. REC'D BY REGISTRAR <u>JUN 20 1967</u> DATE	
		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

08294

08305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15000 Donna Dr.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>15000 Donna Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Adam Bettinger</u> First Middle Last 4. DATE OF DEATH <u>6 4 19 67</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-23-1899</u> 9. AGE (In years last birthday) yrs. <u>68</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quality Control engineer Belco Electronics</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Bettinger</u> 14. MOTHER'S MAIDEN NAME <u>Mary (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Son</u> Address <u>Richard Bettinger 15000 Donna Drive Silver Spring, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>11201 Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>63</u> to <u>6/4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/2/67</u> 19 <u>67</u> , and that death occurred at <u>11:00 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH E. Smith, Jr.</u>		22b. DATE SIGNED <u>6/4/67</u> 22d. ADDRESS <u>Burtonsville, Md</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

cleared by Dr. Ball for signature by Dr. J. Smith

08302

CERTIFICATE OF DEATH

MADE IN THE DEPARTMENT OF HEALTH

INVESTIGATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

DATE OF MARRIAGE

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08306

CERTIFICATE OF DEATH

08295

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>98 Cleburne Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Phyllis</b> Middle <b>Marilyn</b> Last <b>BIGHAM</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1923</b>
9. AGE (In years, last birthday) <b>43 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Denver Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Rudd</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NON2</b>	
17. INFORMANT <b>Attalla</b>		Address <b>Alabama</b> <b>Mr. Billy J. Bigham, 98 Cleburne St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination intra thoracic, and retroperitoneal</b> 410X DUE TO <b>Cardiac surgery with cardiopulmonary bypass</b> (b) <b>Rheumatic heart disease with mitral valvulitis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>May 20</b> , 19 <b>67</b> , to <b>June 6</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>June 6</b> , 19 <b>67</b> , and that death occurred at <b>150PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Perry Ah-TYE, M.D.</b>		22b. DATE SIGNED <b>7 June 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Perry Ah-TYE, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-8-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Attalla Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Attalla, Alabama</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		25. REC'D BY REGISTRAR <b>JUN 9 1967</b>	
ADDRESS <b>1400 Chapin St., N. W. Washington, D. C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08307

CERTIFICATE OF DEATH

08296

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN lb <b>2 HOURS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>Box 233</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BOY</b> Last <b>BOGGS</b>		4. DATE OF DEATH Month <b>6</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-67</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>H. L. Boggs</b>		14. MOTHER'S MAIDEN NAME <b>DORIS ANN OLIVER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MEDICAL RECORDS DEPT.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity.</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/6/1967</b> to <b>6/6</b> , 1967, that (I) (we) last saw the deceased alive on <b>6/6</b> 1967, and that death occurred at <b>10 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>H. S. CELGIN, M. D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>818 MONTGOMERY RD., ELKBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>6-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Red Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Pennington Gap Va</b>
24. FUNERAL DIRECTOR <b>Arthur H. Haight Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles J. J...</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>JUN 12 1967</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08308

CERTIFICATE OF DEATH

08297

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>17-3</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		e. STREET ADDRESS <b>1236 11th Street N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret M. Bond</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1967</b>			
5. SEX <b>7</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1879</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James McNamara</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bowles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-44-9934</b>		17. INFORMANT <b>Sarah A. Wilson-5013 Allen Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest</b> DUE TO <b>Coronary Thrombosis</b> (b) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (c) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ONSET AND DEATH <b>1 day</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial Hemiplegia - right</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1957</b> to <b>June 7, 1967</b> that (I) (we) last saw the deceased alive on <b>June 6, 1967</b> , and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>E. Herbert Bowersfeld</b>		22b. DATE SIGNED <b>6/17/67</b>		22c. PHYSICIAN'S NAME (Type) <b>E. Herbert Bowersfeld</b>	
22d. ADDRESS <b>2401 Calvert St. N. W.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>		
24. FUNERAL DIRECTOR <b>S.H. Hines Co. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>JUN 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08309

CERTIFICATE OF DEATH

08298

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md</u>		c. LENGTH OF STAY IN lb <u>1 1/2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md</u>		d. STREET ADDRESS <u>1369 Nicholson St., NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Corliss H. BOWEN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 July 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WOOD WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WOOD WORKING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Gilbert Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Edna?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS. HELEN M. BOWEN. (Same as #2)</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis (generalized)</u> DUE TO (c) <u>Pneumonitis, urinary tract infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> <u>Several years</u> <u>&gt; 2 weeks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u></u> of work <u></u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 25, 1965</u> to <u>June 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 2, 1967</u> , and that death occurred at <u>12:45 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Hugo G. Graziani</u> <u>for Dr. Sarah Kiehl</u>		22b. DATE SIGNED <u>6/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>		22d. ADDRESS <u>10101 GEORGIA AVE, S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Canal Pl NW Wash DC</u>		25a. REC'D BY REGISTRAR <u></u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 6 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08310

Item #23d Film #G390 6/21/67 DC

CERTIFICATE OF DEATH

08299

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>6807 Fairfax Rd.</b>			
c. LENGTH OF STAY IN 1b <b>11 days</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry F. Bowen</b>				4. DATE OF DEATH Month Day Year <b>6 19 67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Caus.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1898</b>		9. AGE (In years last birthday) yrs. <b>69</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Parkersburg, W., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Edward Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Mary Gove</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-09-4971</b>		17. INFORMANT <b>Nursing Home Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: <b>154X</b> IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO (b) <b>Adeno Carcinoma rectum</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b> <b>48 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4</b> , 19 <b>67</b> , to <b>June 19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 17</b> , 19 <b>67</b> , and that death occurred at <b>11:50 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Harry N. Carlton</b>				22b. DATE SIGNED <b>June 19, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry Carlton</b>	
22d. ADDRESS <b>8811 Colesville Rd. Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sutton Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sutton Hill West Va.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b> <b>Wash. D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

00310

CERTIFICATE OF DEATH

00310

MADE AND DATE: [illegible] PLACE OF BIRTH: [illegible]  
NAME: [illegible] SEX: [illegible] AGE: [illegible]  
DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF MINISTER: [illegible]  
SIGNATURE OF CLERGYMAN: [illegible]  
SIGNATURE OF CHURCH: [illegible]  
SIGNATURE OF BURIAL: [illegible]  
SIGNATURE OF INTERMENT: [illegible]  
SIGNATURE OF FUNERAL: [illegible]  
SIGNATURE OF CREMATION: [illegible]  
SIGNATURE OF OTHER: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in Part I, page 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08311

08300

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>				d. STREET ADDRESS <b>1712 Noyes Land</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALBERT RICHARD BRADLEY</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/29/05</b>	
9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOVERNMENT. CORPS ENG.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT. CORPS ENG.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>ERNEST H. BRADLEY</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE MAE BOLLMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-07-7253</b>			
17. INFORMANT <b>KATHERYNE BRADLEY</b>				Address <b>1712 Noyes Land</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>1810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma of Bladder - Metastatic</b> DUE TO <b>6 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3/10</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , <b>1967</b> , to <b>6/23</b> , <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/23</b> , <b>1967</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph Bloom</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Joseph Bloom</b>				22d. ADDRESS <b>1111 Spring Street Silver Spring Md.</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>26 JUNE 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION (City, town or county) (State) <b>Wheaton MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>KINARDI FUNERAL HOME</b>				ADDRESS <b>7480 GEORGIA AVE NW WASH. DC</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
25a. REGISTRAR'S SIGNATURE <b>Michael Munch</b>				DATE <b>JUN 27 1967</b>			

MEDICAL CERTIFICATION

08311

Montgomery

Silver Spring

17 days

Silver Spring

Holy Cross Hospital of Silver Spring

1712 Hovee Lane

June

23

9/29/02

Male White

USA

Maryland

ERNEST H. BRADLEY

CAROL ANN BRADLEY

288-0123 / 288-0123

Ernest H. Bradley

Ernest H. Bradley

Ernest H. Bradley

Ernest H. Bradley

Ernest H. Bradley

Ernest H. Bradley

08312

## CERTIFICATE OF DEATH

08301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>3227 Blueford Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milton G</u> Middle <u>Bransome</u> Last <u>Bransome</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1921</u> 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OXYGEN THERAPIST</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>D. Stanhope Bransome</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Frates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>142-07-9617</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Myocardial Infarct</u> DUE TO <u>PT Coronary artery occlusion</u> DUE TO <u>Coronary artery Sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>2 days</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>1 June</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>31 May</u> 19 <u>67</u> , and that death occurred at <u>6:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Merton L. White</u>		22b. DATE SIGNED <u>1 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>		22d. ADDRESS <u>9911 Georgia Ave Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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08313

## CERTIFICATE OF DEATH

08302

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Springfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>1 hr 28 min</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>5409 Juliet Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 21, 1967</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee Brown</b>		14. MOTHER'S MAIDEN NAME <b>Joy Ballauf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Springfield</b>		Address <b>Virginia</b> <b>LtCdr Lee Brown, USN, 5409 Juliet Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if (this hospital) attended the deceased from <b>1041 21 Jun 19 67</b> , to <b>1209 21 Jun 19 67</b> , that (if (we) last saw the deceased alive on <b>21 June 1967</b> , and that death occurred at <b>1209 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>T. E. Kelly</b>		22b. DATE SIGNED <b>June 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. E. KELLY, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Naval Medical School</b>	23d. LOCATION (City or Town) (County) (State) <b>NNMC, Bethesda, Md.</b>
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE <b>JUN 29 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

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FOR STATE HEALTH DEPT.

08314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08303

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>705 Crabbe Ave</u>				d. STREET ADDRESS <u>705 Crabbe Ave</u>			
3. NAME OF DECEASED (Type or print) <u>James Allen Brown</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1947</u>	9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph T Brown</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Derry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-468572</u>		17. INFORMANT Address <u>Joseph T. Brown - father same # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Valvular Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D. EXAMINER'S NAME (Type) <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/4/67</u> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08316 CERTIFICATE OF DEATH 08304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirley</u> c. LENGTH OF STAY IN 1b <u>4 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beauregard Foundation</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15.1 d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Norman Burdette</u>			4. DATE OF DEATH Month Day Year <u>June 2 1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/1899</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John J. Burdette</u>				
14. MOTHER'S MAIDEN NAME <u>King, Cora</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>320-32-7327A</u>			17. INFORMANT <u>Dorcas V. Burdette, Item 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral CVA, Chronic pyelonephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1966</u> to <u>June 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1967</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick Moonau</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-2-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frederick Moonau</u>		22d. ADDRESS <u>Medical Center, Sandy Spring, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Grove</u>	23d. LOCATION (City, town or county) (State) <u>Woodfield, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

MEDICAL CERTIFICATION

98316

STATE OF NEW YORK

100000

IN SENATE  
JANUARY 1, 1900  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

(M)

99

3

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH Month Day Year			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 18 1896 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Coronary Insufficiency Acute DUE TO (c) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				22. DATE SIGNED			
John G. Ball				6/3/67			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6-6-67		National Memorial Park		Falls Church Fairfax, Virginia	
24. FUNERAL DIRECTOR by: Ben E. Payne Jr.				25a. ADDRESS 2847 Wilson Blvd Arlington, Va. 22201		25b. REGISTRAR'S SIGNATURE JUN 6 1967	

11331

Correspondence Enclosed

John A. ...

10/10/11

## CERTIFICATE OF DEATH

08306

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>6 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON GROVE</u> <u>15.1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND NURSING HOME 2101 FAIRLAND RD</u>		d. STREET ADDRESS <u>114 Ridge Road</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>E</u> Last <u>BURKETT</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-25-87</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>NOAH KNUPP</u>		14. MOTHER'S MAIDEN NAME <u>LOHR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-2635-8</u>	
17. INFORMANT <u>Hineckley Burkett Detour, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Urinary tract infection</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-7</u> , 19 <u>67</u> , to <u>6-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>67</u> , and that death occurred at <u>1:05 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert B. Cushman</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Gilbert B. Cushman, M.D.</u>		22d. ADDRESS <u>6480 New Hampshire Ave, T. Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE, THEREOF <u>6-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Montg Md</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		ADDRESS <u>Gaithersburg, Md</u>	25a. RECEIVED BY REGISTRAR <u>James B. Gartner</u>
DATE <u>JUN 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James B. Gartner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08312

1 JUN 1961

08315

## CERTIFICATE OF DEATH

08307

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>Route # 1</b>	
3. NAME OF DECEASED (Type or print) <b>MERTIE VIRGINIA BURNS</b> First Middle Last		4. DATE OF DEATH <b>June 25, 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1917</b>
9. AGE (In years last birthday) <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Norman L. Duvall</b>		14. MOTHER'S MAIDEN NAME <b>Hilda P. Burns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family and Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcomatosis</b> <b>1992</b> DUE TO <b>with Right Ventricular Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>Months ?</b> <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>No accident involved.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 11, 1966</b> to <b>June 25, 1967</b> , that (I) <del>(we)</del> <b>we</b> saw the deceased alive on <b>June 25, 1967</b> , and that death occurred at <b>6 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>M. McKendree Boyer</i>		22b. DATE SIGNED <b>June 26, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D.</b>		22d. ADDRESS <b>9701 Church Street Damascus, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Grove Meth.</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodfield, Md.</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth,</b>		25a. REC'D BY REGISTRAR <b>JUN 29 1967</b>	
ADDRESS <b>Damascus, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08312

1. *Introduction*

*Journal of Management Education*

6. 2. 1979

6025-47-1

I have a question

behavioral intentions of

1951/52 21728000

08319

## CERTIFICATE OF DEATH

08308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb <b>Carroll Hall Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>	
3. NAME OF DECEASED (Type or print) <b>Deborah Burrowes</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Library assistant-U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Burrowes</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Herbert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth Coffin same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>493X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2) Cerebral Vascular Accident, etc. &amp; ASD 3) Carcinoma, Breast, Right</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 2</b> , 1967, to <b>11</b> , 1967, that (I) (we) last saw the deceased alive on <b>June 10</b> , 1967, and that death occurred at <b>8:45 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W.F. Cresswell, Jr.</b>		22b. DATE SIGNED <b>June 11 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.F. Cresswell, Jr.</b>		22d. ADDRESS <b>2020 Que St. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>6/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County, Md</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>JUN 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		25c. REGISTRAR'S ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>	

01380

CERTIFICATE OF DEATH

08320

08309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2004 August Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Iida M. Carlson</u>		4. DATE OF DEATH Month Day Year <u>June 6, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard H. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Viola M. McDonald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-24-3999</u>	
17. INFORMANT <u>Hugo H. Carlson</u>		Address <u>2004 August Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19____, to <u>6-6-</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5-9-</u> , 19 <u>67</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8829 Flower Avenue, Silver Spring, Maryland 20901</u> <u>6/6/67</u>			
ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D.		8829 Flower Avenue, Silver Spring, Maryland 20901	
PHYSICIAN'S NAME (Type) <u>Samuel A. Hillman, M.D.</u>		DATE SIGNED <u>6/6/67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9, 1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Amissville Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Amissville, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>JUN 12 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER NOTIFIED  
WILL APPROVE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08310  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12240 Vieters Mill Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12240 Vieters Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <u>David Franklin Carraway</u>		4. DATE OF DEATH <u>June 27 19 67</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 16, 1903</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Pt. Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Agriculture</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Gastonia, North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>James Leake Carraway</u>				14. MOTHER'S MAIDEN NAME <u>Mabel J. Glenn</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>579-38-4443</u>				17. INFORMANT <u>Evelyn B. Carraway</u> Address <u>12240 Vieters Mill Road Silver Spring, Maryland</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarct</u> 4201 DUE TO (b) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>Years.</u>																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u>																											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>July 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 20</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.																											
22a. SIGNATURE <u>Richard P. Delaney</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>June 27, 1967</u>																			
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>				22d. ADDRESS <u>4323 Havard St., Silver Spring, Maryland</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 29, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>18434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 29 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

18821

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Place of Birth	
John Doe		12-25-1900		New York, N.Y.	
Sex		Age at Death		Cause of Death	
Male		42 years		Heart Disease	
Date of Death		Place of Death		Occupation	
10-15-1942		New York, N.Y.		Teacher	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
10-20-1942		New York, N.Y.		[Seal]	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08322

CERTIFICATE OF DEATH

08311

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b> c. LENGTH OF STAY IN 1b <b>151</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6105 Yale Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b> d. STREET ADDRESS <b>6105 Yale Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERNARD H. CARROLL</b>		4. DATE OF DEATH <b>June 8, 1967</b> 19 <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drugs</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leroy Carroll</b>	
14. MOTHER'S MAIDEN NAME <b>Josie Babcock</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>022-09-3337</b>		17. INFORMANT <b>Lois E. Carroll - Item # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Recurrent Cerebral vascular accident 24 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Generalized Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diverterculitis &amp; Rupture into bladder - Resected in 3 stages</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Many years</b> <b>Many years</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 5/17</b> , 19 <b>67</b> to <b>6/8</b> , 19 <b>67</b> that (I) <del>(was)</del> last saw the deceased alive on <b>5/17</b> , 19 <b>67</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. S. Williams</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>ROGER S. WILLIAMS</b>		22b. DATE SIGNED <b>6/8/67</b> 22d. ADDRESS <b>35 NEW YORK AVE NW, WASH DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home-1331 Rockville Pike Rockville, Md.</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b> DATE <b>15 1967</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08323

CERTIFICATE OF DEATH

08312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>10527 Montrose Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Ivan</i> First <i>Wolfermy</i> Middle <i>Caulsen</i> Last		4. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-30-02</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Indiana Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Caulsen</i>		14. MOTHER'S MAIDEN NAME <i>Irma Bogard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>709-14-2428</i>	
17. INFORMANT <i>Lillian Caulsen - wife</i>		Address <i>odd same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanotic Ca</i> DUE TO (b) <i>Ca Rectum</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Perforation duodenum w/ generalized Peritonitis</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2-26</i> , 19 <i>65</i> to <i>6-4</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-4</i> , 19 <i>67</i> , and that death occurred at <i>4:10 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>R. Smith</i>		22b. DATE SIGNED <i>6-5-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. Smith</i>		22d. ADDRESS <i>916-19th St NW Wash DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/8/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md.</i>
24. FUNERAL DIRECTOR <i>Tyson</i>		25a. REC'D BY REGISTRAR <i>JUN 8 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Judge</i>			

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UNITED STATES DEPT. OF AGRICULTURE

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Handwritten notes and signatures, including "M. J. Smith" and "J. H. Smith".

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08324

CERTIFICATE OF DEATH

08313

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8514 Woodhaven Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD R CHENOWITH</u>		4. DATE OF DEATH <u>JUNE 17 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/24/1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Dealer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard R. Chenowith</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Hall Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-05-8630A</u>	
17. INFORMANT <u>Wife - Ann M. Chenowith</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of mesenteric and Rt. Iliac Arteries</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11 June 1967</u> , to <u>17 June 1967</u> , that (I) (we) last saw the deceased alive on <u>16 June 1967</u> , and that death occurred at <u>12:25 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley M. Bialer</u>		22b. DATE SIGNED <u>17 June 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>6-20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DAVID</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08325

CERTIFICATE OF DEATH

08314

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY Co</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN IB <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RES MOR SANTARIUM</b>		d. STREET ADDRESS <b>8425 Woodcliff Court</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ruth ANN</b>		4. DATE OF DEATH Month Day Year <b>June - 17 1967</b>	
5. SEX <b>female</b>		6. COLOR OF RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Dec 11, 1907</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Dakota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John C. Cisar</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Schock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>577-48-6984</b>	
17. INFORMANT <b>Frank A. Cisar</b>		Address <b>8425 Woodcliff Court Silver Spring, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>65</b> to <b>6/17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> 19 <b>67</b> , and that death occurred at <b>3:48</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>6/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIG</b>		22d. ADDRESS <b>8641 Colesville Rd Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>June 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JUN 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

08353

CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08315

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 Holy Cross Hosp.</u>				d. STREET ADDRESS <u>2814 Urbana Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Edward Ernest Clark</u>				4. DATE OF DEATH <u>June 18, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/27/87</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Manassas, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired engineer Washington Terminal</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manassas, Va.</u>			
13. FATHER'S NAME <u>William Anson Clark</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bryant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Edward E. Clark, wife</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Notural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>6/19/1967</u>	
26. ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>				27. DATE <u>JUN 22 1967</u>			

08336

U. S. A.

X

Midland, Maryland

June 21, 1967 Cedar Hill Cemetery

July 2, 1967

John D. ...

John D. ...

John D. ...

6/19/1967

08316

08327

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>26 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>2209 Metzgerott Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin Terrell Clarke</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Planner &amp; Estimator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NOL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John W. Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Ida Perkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Army - WWII</u>		16. SOCIAL SECURITY NO. <u>049-05-9697A</u>	
17. INFORMANT <u>Mrs. Mildred Clarke</u>		Address <u>2209 Metzgerott Rd. Adelphi, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-5, 1967</u> to <u>6-6, 1967</u> that (I) (we) last saw the deceased alive on <u>6-6, 1967</u> and that death occurred at <u>12:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Jason Greiger, M.D.</u>		22b. DATE SIGNED <u>6-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jason Greiger, M.D.</u>		22d. ADDRESS <u>800 Pershing Drive Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

7560

08328

## CERTIFICATE OF DEATH

08317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Cty</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>10229 Capital View Ave</u>	
3. NAME OF DECEASED (Type or print) <u>BERTA GLADYS COFFEE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (In years last birthday) <u>81</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MILAN INDIANA (Ripley County)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Joseph Peters</u>		14. MOTHER'S MAIDEN NAME <u>Jessie F. Sutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-6143</u>	
17. INFORMANT (Daughter) <u>Lois CAIN</u>		Address <u>10229 Capital View Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E COLI SEPTICEMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED PERITONITIS</u> DUE TO (c) <u>STATUS POST RESECTION-CARCINOMA COLON</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>5 DAYS</u> <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1538</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-6-1967</u> to <u>6-11-1967</u> , that (I) (we) last saw the deceased alive on <u>6-11-1967</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John P. Haberlin</u>		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>		22d. ADDRESS <u>1015 Spring St., Silver Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>June 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stumpkes Corner Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Milan, Indiana</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>8434 Georgia Avenue</u>	25. REC'D BY REGISTRAR <u>JUN 14 1967</u>
<u>Warner E. Pumphrey, Inc.</u>		<u>Silver Spring, Md.</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

08815

CERTIFICATE OF DEATH

08833

Name of Deceased		Date of Birth		Sex	
John D. Doe		1912-01-15		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		1978-03-10		Heart Disease	
Occupation		Residence		Manner of Death	
Teacher		123 Main St, New York, NY		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued by		Official Seal	
1978-03-15		John Doe, Registrar		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08329

CERTIFICATE OF DEATH

08318

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Trenton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fakema Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trenton</u>	
c. LENGTH OF STAY IN 1b <u>Weeks</u>		d. STREET ADDRESS <u>203 Ellwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First <u>Mabel</u> Middle <u>I</u> Last <u>Coley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office worker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Coley</u>		14. MOTHER'S MAIDEN NAME <u>Eva Carr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Spine</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sign</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Hour a.m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/67</u> , 19 <u>67</u> , to <u>6/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/3</u> , 19 <u>67</u> , and that death occurred at <u>12:00 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>June 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		22d. ADDRESS <u>831 University Blvd E., Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Trenton New Jersey</u>
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Canal St NW, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 6 1967</u>	

100-1

EXHIBIT IN CASE

100-1

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

08330		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		08319	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN b <u>151</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> d. STREET ADDRESS <u>6701 Westmoreland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>marie G. Collins</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-16</u>	9. AGE (In years last birthday) yrs. <u>50</u>	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John B. Keason</u>			
14. MOTHER'S MAIDEN NAME <u>Anne Marie Brennan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son - Bernard Collins</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(Pneumonia)</u> / <u>Acute fatty metamorphosis of liver</u> DUE TO (b) <u>Malnutrition and chronic alcoholism</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>JOHN G. BALL</u>		22. DATE SIGNED <u>6/9/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>June 12 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, P. Dec. Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll Rd NW AC</u>		25. REC'D BY REGISTRAR DATE <u>JUN 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00330

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*Jim H. Bell*

2 6/1/01

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08331

CERTIFICATE OF DEATH

08320

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Dist. of Columbia</b> b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>43 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>4704 Brinkley Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jeanne Wilson COLVIN</b>		4. DATE OF DEATH Month Day Year <b>June 22 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1931</b>
9. AGE (In years lost birthday) <b>35 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>22 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher/Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburg, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Vandegrift</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Washington, D.C. Address 20031</b> <b>ICol H. Clifford Colvin, 4704 Brinkley Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive subarachnoid and subdural hemorrhage</b> <b>secondary to hemorrhagic diathesis associated with</b> <b>lymphosarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>lymphosarcoma</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>May 10</b> , 19 <b>67</b> , to <b>June 22</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>June 22</b> , 19 <b>67</b> , and that death occurred at <b>725PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Davis R. Foreman</b>		22b. DATE SIGNED <b>June 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Davis R. Foreman, M. D.</b>		22d. ADDRESS <b>Navy Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-26-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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08332

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>36 days</u>		d. STREET ADDRESS <u>10009 Greenock Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Curtis Carl Combs</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-13</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Titus Co., Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Combs</u>		14. MOTHER'S MAIDEN NAME <u>Tommie Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>577-24-6782</u>	
17. INFORMANT <u>Mrs. Wilma Combs (wife)</u>		Address <u>10009 Greenock Rd Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5020 Bronchitis &amp; Emphysema</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1966</u> , to <u>June 23, 1967</u> , that (I) (we) las saw the deceased alive on <u>June 22, 1967</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert C. Macon</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6/23/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Macon M.D.</u>		22d. ADDRESS <u>809 Viers Mill Road, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>June 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>XXXXXXXXXXXXXXXXXXXX</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Pleasant, Texas</u>
24. FUNERAL DIRECTOR <u>C. Glenn Carter</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ORIGINAL OF DEATH

05330

1942-11-17

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08333

08322

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				d. STREET ADDRESS <i>7415 Oak Lane</i>			
3. NAME OF DECEASED (Type or print) <i>Myra Vogel Coons</i>				4. DATE OF DEATH <i>June 4 1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-2-83</i>	9. AGE (In years, months, and days) <i>83 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Chesley - Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles W. Vogel</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Neuffer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-36-5744</i>		17. INFORMANT <i>Mr. George H. Coons - Chese</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cerebrovascular Disease</i> 334X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>Years 3</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fall at home causing fracture of hip &amp; wrist.</i>			
20c. TIME OF INJURY Month, Day, Year <i>10:30 p.m. 5/3 1967</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
				20f. (City or town) (County) (State) <i>Cherry Chase Mont. Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>				22. DATE SIGNED <i>6/4/67</i>			
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>6-7-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FOREST HILLS Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Ann Arbor Mich</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR <i>7557 Wisc Ave Bethesda Md.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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John H. ...

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James M. Smith

10/10/19

Charles W. Jones

511-38-254

11/11/11

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17/1/2020

1890

## CERTIFICATE OF DEATH

08323

08334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 wks.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4720 Chevy Chase Drive</u>		d. STREET ADDRESS <u>4720 Chevy Chase Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Adele Beall</u> Middle <u>CURRAN</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-88</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph M. CURRAN</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Devine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-60-9100</u>	
17. INFORMANT <u>Miss Mildred BURROWS Bethesda Md.</u>		Address <u>4720 Chevy Chase Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, severe with coronary sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatic mitral disease, mild</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 3</u> , 19 <u>56</u> to <u>June 8</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>June 8</u> , 19 <u>67</u> , and that death occurred at <u>9:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas A. Wildman</u>		22b. DATE SIGNED <u>June 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS A. WILDMAN</u>		22d. ADDRESS <u>3729 Morrison St. NW, Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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4320 The ...

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100-330

THOMAS A. WILSON

100-330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08335

CERTIFICATE OF DEATH

08324

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 month</u>		d. STREET ADDRESS <u>14507 FAIRACRES RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carolyn</u> First Middle Last <u>Davis</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/16/23</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist- Naval Ord. Lab.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Potts. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donald G. Lerch</u>		14. MOTHER'S MAIDEN NAME <u>Ann Leister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Same as #2d</u> Address <u>John R. Davis, Jr. Husband</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO (b) <u>Adenocarcinoma of Colon due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Ulcerative Colitis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u> <u>few yrs.</u> <u>many yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>63</u> , to <u>6/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>67</u> , and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/19/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>6-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

66834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08336

CERTIFICATE OF DEATH

08325

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guthrieburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Franklin Day</u>		4. DATE OF DEATH <u>6-11-1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Day</u>		14. MOTHER'S MAIDEN NAME <u>Lucilla Ingalls</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Sister - Catherine May - Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive failure</u> DUE TO <u>A.S.H.W.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS.H.W.</u> DUE TO (c) <u>AS.H.W.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Poss. g. u. or g. b. infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5/29/1967</u> to <u>6/11/1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6/11/1967</u> , and that death occurred at <u>10:00</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisc. Av. - Beth Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>	23d. LOCATION (City or Town) (County) (State) <u>Goshen Mont. Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REGD. BY REGISTRAR <u>JUN 14 1967</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

083330

Franklin

Francis N. Barber, Louisville, Mo.  
Serial 1-12-57  
Checked

Coastal Route No.

08337

## CERTIFICATE OF DEATH

08326

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>26 Naval Hospital</u>				d. STREET ADDRESS <u>2216 Washington Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>P.</u> Last <u>DIELTZ</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 30, 1906</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pope County, Minnesota</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John P. Dieltz</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Clara Clemens</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes 1924-1935</u>			
16. SOCIAL SECURITY NO. <u>220 34 4914</u>				17. INFORMANT <u>Ave., Silver Spring, Md.</u> <u>Mrs. Pauline G. Dieltz, 2216 Washington</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(this hospital)</del> attended the deceased from <u>June 25</u> , 19 <u>67</u> , to <u>June 28</u> , 19 <u>67</u> , that <del>(we)</del> saw the deceased alive on <u>June 28</u> , 19 <u>67</u> , and that death occurred at <u>1010 M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>30 June 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>M. J. FOUTY, M. D.</u>	
22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</u>				25a. REGISTERED REGISTRAR <u>JUL 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2582

76680

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08327

FOR STATE HEALTH DEPT. M

08335

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN lb <u>13 years</u>				d. STREET ADDRESS <u>2305 Dennis Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2305 Dennis Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Robert Dimond</u>				4. DATE OF DEATH Month Day Year <u>June 26 19 67</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1895</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Correspondence Clerk Dept of Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Dimond</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mary Flynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Helen M. Dimond</u>				Address <u>2305 Dennis Avenue Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>							
DUE TO (b) <u>11201</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6/26/67</u>			
BETHESDA, MD.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Glen Carter</u>				24a. REG'D BY REGISTRAR <u>11/11/67</u>			
Address <u>4843 Georgia Avenue</u>				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
Warner E. Pumphrey, Inc. Silver Spring, Md.				DATE			

RECEIVED  
JUN 10 1964  
U.S. AIR FORCE  
MEDICAL CENTER  
WASHINGTON, D.C.

03000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Social Security Number		8. Occupation		9. Usual Residence		10. Address at Time of Death	
11. Cause of Death		12. Manner of Death		13. Signature of Medical Examiner		14. Signature of Coroner		15. Signature of Registrar	
16. Date of Autopsy		17. Name of Pathologist		18. Name of Hospital		19. Name of Physician		20. Name of Nurse	
21. Name of Undertaker		22. Name of Funeral Home		23. Name of Cemetery		24. Name of Burial Place		25. Name of Interment Place	
26. Name of Burial Place		27. Name of Interment Place		28. Name of Burial Place		29. Name of Interment Place		30. Name of Burial Place	
31. Name of Interment Place		32. Name of Burial Place		33. Name of Interment Place		34. Name of Burial Place		35. Name of Interment Place	
36. Name of Burial Place		37. Name of Interment Place		38. Name of Burial Place		39. Name of Interment Place		40. Name of Burial Place	
41. Name of Interment Place		42. Name of Burial Place		43. Name of Interment Place		44. Name of Burial Place		45. Name of Interment Place	
46. Name of Burial Place		47. Name of Interment Place		48. Name of Burial Place		49. Name of Interment Place		50. Name of Burial Place	
51. Name of Interment Place		52. Name of Burial Place		53. Name of Interment Place		54. Name of Burial Place		55. Name of Interment Place	
56. Name of Burial Place		57. Name of Interment Place		58. Name of Burial Place		59. Name of Interment Place		60. Name of Burial Place	
61. Name of Interment Place		62. Name of Burial Place		63. Name of Interment Place		64. Name of Burial Place		65. Name of Interment Place	
66. Name of Burial Place		67. Name of Interment Place		68. Name of Burial Place		69. Name of Interment Place		70. Name of Burial Place	
71. Name of Interment Place		72. Name of Burial Place		73. Name of Interment Place		74. Name of Burial Place		75. Name of Interment Place	
76. Name of Burial Place		77. Name of Interment Place		78. Name of Burial Place		79. Name of Interment Place		80. Name of Burial Place	
81. Name of Interment Place		82. Name of Burial Place		83. Name of Interment Place		84. Name of Burial Place		85. Name of Interment Place	
86. Name of Burial Place		87. Name of Interment Place		88. Name of Burial Place		89. Name of Interment Place		90. Name of Burial Place	
91. Name of Interment Place		92. Name of Burial Place		93. Name of Interment Place		94. Name of Burial Place		95. Name of Interment Place	
96. Name of Burial Place		97. Name of Interment Place		98. Name of Burial Place		99. Name of Interment Place		100. Name of Burial Place	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY in 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Ekomia Park</u>		d. STREET ADDRESS <u>7701 Eastern Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Olive A. Donaldson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/1888</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Frederick DeJoseph</u> Address <u>5015 Brunner</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency -</u> DUE TO (b) <u>Cardio Vascular Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>80 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>6/25/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Prince Geo. Co. Md</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08340						08329					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>-</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>5708 Newington Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Madeline B. D. Donnelly</u>						4. DATE OF DEATH <u>June 21 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>5/31/92</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH H. BYRNE</u>						14. MOTHER'S MAIDEN NAME <u>ROSA L. CLINE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN L. DONNELLY</u> Address <u>5708 Newington Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular disease, aortic</u> DUE TO <u>aortic stenosis, aortic regurgitation</u> (b) <u>mitral stenosis</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple pulmonary infarcts</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>67</u> , to <u>6/21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/20</u> 19 <u>67</u> and that death occurred at <u>6:34</u> M, from causes on and on the date stated above											
22a. SIGNATURE <u>Robert R. Montgomery</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/21/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. MONTGOMERY</u>						22d. ADDRESS <u>5411 CEDAR LANE BETHESDA, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-24-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Alexandria, VA</u>					
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08080

STATE OF DEATH

08080



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08341

CERTIFICATE OF DEATH

08330

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>219-A. So. HAMPTON-TRIVE</u>		d. STREET ADDRESS <u>219-A. So. HAMPTON-TR</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH</u> <u>WERNBURG</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>19</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 9-1896</u>
9. AGE (In years, months, and days) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>70</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH KREUTZ</u>		14. MOTHER'S MAIDEN NAME <u>GILLOUS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>70TH MARPLE</u>	
17. INFORMANT <u>70TH MARPLE</u>		Address <u>9201-N. H AVE.</u> <u>SILVER SPRING</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>4-1hr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-1hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1966, to <u>June 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 5</u> , 1967, and that death occurred at <u>6 A M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom MD.</u>		22b. DATE SIGNED <u>6-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD.</u>		22d. ADDRESS <u>7701 Carroll Ave Takoma Park Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>June 21-1967</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Ed. Ford Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Waters</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1934

CENTRAL OF MICHIGAN

1934

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08331

FOR STATE  
HEALTH DEPT

08342

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN U.S. <u>XXXXX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>13225 Clifton Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Barrett Dorsey</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/14</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>computer programmer U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Francis Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Barrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes Navy-WWII</u>		16. SOCIAL SECURITY NO. <u>579-03-0469</u>	
17. INFORMANT <u>Dorothea Dorsey, wife</u>		Address <u>13225 Clifton Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>June 18, 1967</u>	
EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D., Wheaton</u>		Address (Street, city, town, or county) <u>18434 Georgia Avenue Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

3463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08343

CERTIFICATE OF DEATH

08332

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Dist. of Col.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		e. STREET ADDRESS <b>5415 Connecticut Ave. N.W.</b> 47-3 f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last <b>EILEEN ANNA DOWD</b>		4. DATE OF DEATH Month Day Year <b>JUNE 14 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-3-1902</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Secretary N.I.H.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Dowd</b>		14. MOTHER'S MAIDEN NAME <b>Mary F. Gorman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>578-08-6434</b>	
17. INFORMANT <b>See Item No. 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Polycythemia Vera</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 + years</b> <b>10 + years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1946</b> , to <b>June 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 12 1967</b> , and that death occurred at <b>7 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John E. Morris</b> M.D.		22b. DATE SIGNED <b>6/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN E. MORRIS, M.D.</b>		22d. ADDRESS <b>1746 K St., N.W., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-17-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., Washington, D.C.</b>		25a. RECEIVED BY REGISTRAR <b>JUN 19 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

93343

UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

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FOR STATE  
HEALTH DEPT.

083344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08334

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>N.Y.</b> b. COUNTY <b>Cruger Ave.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bronx, N.Y.</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>2009 Cruger Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San. and Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hyman - None - Dreskin</b>		4. DATE OF DEATH Month <b>6</b> Day <b>12</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <b>71</b> yrs.
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>	
13. FATHER'S NAME <b>Solomon Dreskin</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son (Theodore Dreskin)</b>		Address <b>1014 Osage St S.S., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		22. DATE SIGNED <b>June 12, 1967</b>	
EXAMINER'S NAME (Type) <b>BELOEN R. REAP M.D.</b>		Address (Street, City, Town or County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>6/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth El Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Emerson, New Jersey</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>JUN 14 1967</b>	
ADDRESS <b>3501-14th St. NW, Wash. DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

08334

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*Countdown to the 21st Century*

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## CERTIFICATE OF DEATH

08335

08345

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.B.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>25 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1204 Jackson Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles A Durkin</u>		4. DATE OF DEATH <u>June 12 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Evening Star Newspaper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Durkin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jurgeson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-8715</u>	
17. INFORMANT <u>Esther M. Durkin</u>		Address <u>1204 Jackson Avenue, Takoma Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4500</u> IMMEDIATE CAUSE (a) <u>MESENTERIC ARTERY OCCLUSION</u> DUE TO (b) <u>MESENTERIC ARTERY ATHEROSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CONGESTIVE HEART FAILURE, ATHEROSCLEROTIC HEART DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>8 JUNE 10, 1967</u> , to <u>JUNE 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 12 1967</u> , and that death occurred at <u>1:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward G. Beeman</u> M.D.		22b. DATE SIGNED <u>JUNE 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN MD</u>		22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>48434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

3552

STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

SIXTH JUDICIAL DISTRICT

OF THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

PLAINT FOR

RECOVERY OF

PROPERTY

AND

FORFEITURE

OF

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TO

THE

STATE OF TEXAS

VS.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08346

CERTIFICATE OF DEATH

08336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>#6 Elgar Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Michael John Eader</u>		4. DATE OF DEATH <u>June 11 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chatterbox Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archie W. Eader</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Eader</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-42-1590</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Laennec's cirrhosis</u> DUE TO (c) <u>sevl. yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal failure 2° to above</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>June 11, 1967</u> , that (I) (we) lost saw the deceased alive on <u>June 11, 1967</u> , and that death occurred at <u>8:30 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>6/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wic. Ave. Beth., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or town) (County) (State) <u>Gaithersburg Montg Md</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
ADDRESS <u>Gaithersburg Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

7288

Feb 01

[illegible]

FOR STATE  
HEALTH DEPT.

08347

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08337

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> c. LENGTH OF STAY IN 1b <b>4 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>219 Cedar Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>219 Cedar Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES M. EASTON</b>				4. DATE OF DEATH Month Day Year <b>June 11, 1967 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1924</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Golf Pro.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Golfing</b>		13. FATHER'S NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>219-03-2732</b>		17. INFORMANT <b>Verna F. Easton- Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency, Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>4201</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John G. Ball</b>				22. DATE SIGNED <b>6/12/67</b>			
EXAMINER'S NAME (Type) <b>John G. Ball-Bethesda, Md.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>1331 Rock. Pike</b>		25a. REC'D BY REGISTRAR <b>JUN 15 1967</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1967

MEMORANDUM FOR THE RECORD

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

08348

CERTIFICATE OF DEATH

08338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Classified with Medical Examiners Office*

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>16 hr - 45 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Suburban Hospital</u>		d. STREET ADDRESS <u>6750 S.W. 8th St</u>	
3. NAME OF DECEASED (Type or print) <u>Charles W Erdlitz</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-88</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Menominee, Mich</u>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Frank Erdlitz</u>		14. MOTHER'S MAIDEN NAME <u>B. Friedel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>138-09-3360A</u>	
17. INFORMANT <u>John Erdlitz</u>		Address <u>Gaithersburg, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>33 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1967</u> , to <u>June 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1967</u> , and that death occurred at <u>2:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen C. Cromwell</u>		22b. DATE SIGNED <u>6-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Menominee</u>	23d. LOCATION (City or Town) (County) (State) <u>Mich, Menominee Mich</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 20 1967</u>	

1933

CERTIFICATE OF DEATH

74330

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		Jan 15, 1933	
Place of Death		New York City	
Cause of Death		Heart Disease	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan 16, 1933	
Place of Registration		New York City	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

08349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>299.48 min</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>100 Charles St</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond Russell Etchison</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4-1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Raymond Etchison</u>		14. MOTHER'S MAIDEN NAME <u>Frances Emma Jean Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-54-6480</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intra-peritoneal hemorrhage</u> DUE TO (b) <u>Rupture of spleen</u> DUE TO (c) <u>Trauma from automobile accident</u>		INTERVAL BETWEEN SET AND DEATH <u>12 hrs</u> ditto ditto	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car - run off highway</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:15</u> Hour <u>p.m.</u> <u>6/5</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Darnestown, Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>6/6/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 8 1967</u>	

6313

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08350

# CERTIFICATE OF DEATH

08340

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 473</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1439 Rhode Island Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>THOMAS H. FALLIN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH S. DENTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>579-60-1557</u>	
17. INFORMANT <u>MRS CHAS. A. COURT</u>		Address <u>RAINSWOOD, VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Damage</u> DUE TO <u>Cardiac arrest</u> DUE TO <u>acute myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-31</u> , 19 <u>67</u> , to <u>6-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-4</u> , 19 <u>67</u> , and that death occurred at <u>6:17 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Ostrow</u>		22b. DATE SIGNED <u>6-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>		22d. ADDRESS <u>8107 EASTERN AVE. S.S., Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUN 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HELGROSE METH. CH. CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>LOUISBURG, VIRGINIA</u>
24. FUNERAL DIRECTOR <u>J. W. WILKE &amp; SONS, 300 4TH ST. NE. WASH. DC</u>		25. REC'D BY REGISTRAR <u>JUN 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

00000

STATE OF TEXAS

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NOTICE TO THE PUBLIC  
The undersigned, being a duly qualified and licensed  
Notary Public in and for the State of Texas, do hereby  
certify that the foregoing is a true and correct  
copy of the original as the same appears in the  
records of the County of \_\_\_\_\_ State of Texas.

08351

CERTIFICATE OF DEATH

08341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Lehigh</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gettysburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>47 North Jefferson St.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Aloysius</u> Middle <u>Farell</u> Last		4. DATE OF DEATH <u>6-4</u> Month <u>1967</u> Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1885</u> 9. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Farell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cavanaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-01-5989</u>	
17. INFORMANT <u>Mrs. Shelton-niece-</u> Address <u>4421 Chestnut Bethesda</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>Cancer of Surg</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>24 April 1967</u> to <u>4 June 1967</u> , that (I) (we) last saw the deceased alive on <u>4 June 1967</u> , and that death occurred at <u>3 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A.H. Richwine</u> M.D.		22b. DATE SIGNED <u>4 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.H. RICHWINE</u>		22d. ADDRESS <u>3522 WESTERN AVE CHEVY CHASE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Patterson, N.J.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

13230

THE STATE OF TEXAS

1885

Witness my hand and seal this 1st day of January, 1885.  
Attest:  
Notary Public for Texas,  
J. A. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08352

CERTIFICATE OF DEATH

08342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Andrew</u> Last <u>Fetrow</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1954</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George M. Fetrow</u>		14. MOTHER'S MAIDEN NAME <u>Joanne Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXXX</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>2893</u> IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO (b) <u>Bronchiectasis</u> DUE TO (c) <u>Cystic Fibrosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u> <u>since birth</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 12</u> , 19 <u>67</u> , to <u>June 15</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 15</u> , 19 <u>67</u> , and that death occurred at <u>8:50 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Georges Peter</u>		22b. DATE SIGNED <u>P.M. June 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Georges Peter, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>DAVID</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>JUN 21 1967</u>	

SECRET

UNITED STATES DEPARTMENT OF THE ARMY

32330

UNITED STATES DEPARTMENT OF THE ARMY

WASHINGTON, D.C. 20315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08353

CERTIFICATE OF DEATH

08343

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>64 days</b>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Albans</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>2349 Winter Street</b>	
3. NAME OF DECEASED (Type or print) <b>Joe Keith Fisher</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 December 1956</b>
9. AGE (In years lost birthday) <b>10 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles K. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Barbara J. Currey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, fungal</b> DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>30 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>April 24</b> , 19 <b>67</b> , to <b>June 27</b> , 19 <b>67</b> , that <b>XX</b> (we) lost saw the deceased alive on <b>June 27</b> , 19 <b>67</b> , and that death occurred at <b>10:29 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Roland T. Skeel, M.D.</b>		22b. DATE SIGNED <b>6/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Roland T. Skeel, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Tyler mountain mem garden</b>		23d. LOCATION (City or Town) (County) (State) <b>Charleston W. Va</b>	
24. FUNERAL DIRECTOR <b>Robert A. Deibel</b>		25a. REC'D BY REGISTRAR <b>Washington D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 30 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1412 Kanawha St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hopt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fitzpatrick</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) yrs. <u>5</u> <u>16</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James V. Jr.</u>		14. MOTHER'S MAIDEN NAME <u>MARY SIMMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JAMES V. Fitzpatrick Jr. Hyattsville Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6:34 P.M. 6/23, 1967</u> , to <u>11:50 P.M. 6/23, 1967</u> , that (I) (we) last saw the deceased alive on <u>6/23/1967</u> , and that death occurred at <u>11:50 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph G. Dugan</u>		22b. DATE SIGNED <u>6/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH A. DUGAN, M.D.</u>		22d. ADDRESS <u>50 W. EDMONSTON DR, ROCKVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rockville, Pike, Rock. Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

6-776254



08346

## CERTIFICATE OF DEATH

08355

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>16½ years</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7723 Eastern Avenue</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. STREET ADDRESS <i>7723 Eastern Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mand M. Flagg</i> First Middle Last 4. DATE OF DEATH <i>June 3 1967</i> Month Day Year		5. SEX <i>female</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Aug 22, 1870</i> 9. AGE (In years last birthday) <i>96</i> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John E. Miller</i> 14. MOTHER'S MAIDEN NAME <i>Katherine Hager</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> 16. SOCIAL SECURITY NO. <i>213-56-0005-21</i> 17. INFORMANT <i>Burr M. Flagg</i> Address <i>7723 Eastern Ave. Takoma Park, Md.</i>			
18. MEDICAL CERTIFICATION IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>TERMINAL PULMONARY EDema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Arturo - sclerotic Heart Disease</i> DUE TO (c) <i>Arturo - sclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item IB.)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> , 19 <i>48</i> , to <i>6/3</i> , 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>5/11</i> , 19 <i>67</i> , and that death occurred at <i>9:15 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Francis X. Richardson</i> 22c. PHYSICIAN'S NAME (Type) <i>Francis X. Richardson</i>		22b. DATE SIGNED <i>6/3</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>11412 Viers Mill Rd., Wheaton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>June 5, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>New Norborne Cemetery</i> 23d. LOCATION (City or Town) (County) (State) <i>Martinsburg, W. Virginia</i>		24. FUNERAL DIRECTOR <i>C. Glen Carter</i> ADDRESS <i>4434 Georgia Avenue</i> <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i> 25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. Belden Rap - Medical Examiner  
Notified and Autopsy signed with this Agency*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

INA M. FLORINE

08356

08347

PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park</u>		d. STREET ADDRESS <u>8221 14th Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florine</u> First Middle Last <u>INA M.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Natural Disposition</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Munro</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fornie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John A. Routhier, 12908 Evanston, Rockville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Cerebrovascular Accident</u> DUE TO (c) <u>Hypertensive C-V. Disease</u>		INTERVAL BETWEEN INSTANT DEATH <u>2 wk</u> <u>Yes</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>67</u> to <u>6/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/11</u> , 19 <u>67</u> , and that death occurred on <u>6/10</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>C. H. HIGDON</u>	
22b. DATE SIGNED <u>6/10/67</u>		22c. PHYSICIAN'S NAME (Type) <u>C. H. HIGDON</u>	
22d. ADDRESS <u>Sandy Spring, Md</u>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. ADDRESS <u>25 Carroll St NW Washington D.C.</u>		25c. DATE <u>JUN 12 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

08357		CERTIFICATE OF DEATH		08348	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> <i>15-1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11610 Split Rail Court</i>		d. STREET ADDRESS <i>11610 Split Rail Court</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Chester</i> Middle <i>Arthur</i> Last <i>Forrest</i>		4. DATE OF DEATH Month <i>June</i> Day <i>9</i> Year <i>19 67</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3, 1882</i>		9. AGE (In years last birthday) <i>85</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D. C. Govt.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Leven James Forrest</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Callis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-07-6456</i>		17. INFORMANT <i>W. H. Forrest</i> <i>11610 Split Rail Court</i> <i>Rockville, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Occlusion</i> <i>H201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>May 23 1967</i> , to <i>June 9</i> , 19 <i>67</i> that I last saw the deceased alive on <i>May 23</i> , 19 <i>67</i> , and that death occurred at <i>6:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <i>6-9-67</i>					
ACTUAL SIGNATURE <i>George A. Boivin</i> M.D. _____					
PHYSICIAN'S NAME (Type) <i>George A. Boivin M.D.</i> <i>5410 Conn. Ave., N. W., Washington, D. C.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 12, 1967</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
22d. LOCATION (City, town, or county) (State) <i>Switland Maryland</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		24a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>JUN 14 1967</i>	
24b. REGISTRAR'S SIGNATURE					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Items 18-21 Film 390 7- MARYLAND STATE DEPARTMENT OF HEALTH  
7-13-67 and DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN + Hospital</u>		d. STREET ADDRESS <u>7402 HANCOCK AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>BRAZIER</u> Middle <u>FRANCIS</u> Last <u>JR</u>		4. DATE OF DEATH <u>6</u> - <u>4</u> 19 <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-02</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM BRAZIER FRANCIS</u>		14. MOTHER'S MAIDEN NAME <u>SADIE COLTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>PALLA LYNN FRANCIS (daughter)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple skull fractures with intracranial</u> DUE TO (b) <u>hemorrhage due to fall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell down stairs at home.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>15</u> Hour a.m. <u>6-4</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Takoma Park</u> <u>Pr. Geo.</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>June 4, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland Rd. Pr. Geo. Md</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>254 Carroll St</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 6 1967</u>			

MEDICAL CERTIFICATION

16

2



08359

Item #1d Film #G390 6/30/67 DC

## CERTIFICATE OF DEATH

08350

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Indiana</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monroeville</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7413 Birch Avenue</i>		d. STREET ADDRESS <i>3015 W. Meridian St.</i>	
3. NAME OF DECEASED (Type or print) <i>Frances Elliott French</i>		4. DATE OF DEATH <i>June 15 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 6 1872</i>
9. AGE (In years last birthday) <i>95</i> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Monroeville, Ind.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>William Montgomerie French</i>		14. MOTHER'S MAIDEN NAME <i>Missouri Ann Garrison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>31948-7668</i>	
17. INFORMANT <i>Miss Ralph E French</i>		Address <i>7413 Birch Ave. Parkersburg, W. Va.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cornary Cell</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Chc Reg Myocarditis &amp; Decomp</i> DUE TO (c) <i>Arr arr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/19/67</i> , 19 to <i>6/25/67</i> , 1967; that (I) (we) lost saw the deceased alive on <i>6/25/67</i> , and that death occurred at <i>4:05</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Howard T Morse</i> M.D.		22b. DATE SIGNED <i>6/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T Morse M.D.</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Crema</i>	23b. DATE THEREOF <i>29 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fairfield Friends Burial</i>	23d. LOCATION (City or Town) (County) (State) <i>Marion Co. Ind.</i>
24. FUNERAL DIRECTOR <i>John R. Taylor</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>254 Carroll St NW</i>		DATE <i>JUN 27 1967</i>	

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RECEIVED

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CERTIFICATE OF DEATH

08360

08361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San and Hosp</u>				d. STREET ADDRESS <u>1204 Lebanon St.</u>			
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>NONE</u> Middle <u>Friedman</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-90</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME <u>Harris Friedman</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Zimmerman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>World War</u>			
16. SOCIAL SECURITY NO. <u>579-07-8977</u>				17. INFORMANT <u>Patient's Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary Thrombosis</u> (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO <u>Unknown</u> (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema of lungs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>67</u> , to <u>6-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-12</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>831 Univ. Blvd. E. Lib. Sp. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Natl. Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Takoma Park, D.C.</u>	
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>				ADDRESS <u>4217 9th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08361

CERTIFICATE OF DEATH

08352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Atlantic</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>68 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pleasantville</u> 67.3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>508 Martin Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Fuhrman</u>			4. DATE OF DEATH Month Day Year <u>June 10 1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April 1942</u>		9. AGE (In years last birthday) yrs. <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Harry W. Fuhrman</u>		
14. MOTHER'S MAIDEN NAME <u>Mildred Little</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1960-1964</u>		
16. SOCIAL SECURITY NO. <u>152-32-1648</u>			17. INFORMANT <u>The Medical Record</u> Address <u>20014 The Clinical Center, Bethesda, Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myelogenous leukemia</u> DUE TO (c) <u>21 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>E coli and pseudomonas septicemia; cerebral edema (at post)</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3 April 1967</u> , to <u>10 June 1967</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>10 June 1967</u> , and that death occurred at <u>9:00 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. Kierney</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carl Kierney, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Pleasantville, New Jersey</u>		24. FUNERAL DIRECTOR <u>John B. Thomas</u> Address <u>Warner E. Pumphrey, Inc. 8434 Georgia Ave.</u>			
25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>			

0-25353-22

1998

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08353

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>1 HR 3 min</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> <b>15-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		d. STREET ADDRESS <b>14706 CROSS WAY RD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILIAN Krause GADDIS</b>		4. DATE OF DEATH Month Day Year <b>JUNE 29 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/7/06</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECT. TREASURER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>ARAB PEST CONTROL</b>		11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK KRAUSE</b>	
14. MOTHER'S MAIDEN NAME <b>MATILDA Ohlenbrisch</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>465-03-9863</b>		17. INFORMANT <b>Herschel Gaddis</b> <b>HUSBAND → HERSCHEL - SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction -</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis -</b> DUE TO (c) <b>Recent -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Recent -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Recent -</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>6/29/67</b>		23. ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>John G. Ball</b> ADDRESS <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL-Special <b>Trans-Burial</b>		23b. DATE THEREOF <b>July 5, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moulton Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Moulton, Texas</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>434 Georgia Avenue Silver Spring, Md.</b>	

08322

08322

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

CERTIFICATE OF DEATH

08363

08354

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>42 mins</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10225 Kenington Plwy</u>	
3. NAME OF DECEASED (Type or print) <u>JULIUS DAVID GELLEE</u>		4. DATE OF DEATH <u>June 26 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1914</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGEMENT ANALYST U.S.P.O. DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.P.O. DEPT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Denver, Colo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Philip Gellie</u>		14. MOTHER'S MAIDEN NAME <u>Lena Kaufman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>523-09-4069</u>	
17. INFORMANT <u>Wife, Betty Gellie</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour :m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (his hospital) attended the deceased from <u>June 13, 1967</u> , to <u>June 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 29 1967</u> , and that death occurred at <u>8:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Orville W. Donnelly</u>		22b. DATE SIGNED <u>26 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ORVILLE W. DONNELLY</u>		22d. ADDRESS <u>2141 R ST. NW Washington D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. VERO CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>ARADORE COUNTY COLO</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217 M ST. N.W.</u>		25a. REC'D BY REGISTRAR <u>JUN 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10-10-10

10-10-10



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08364

08355

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Other</u> First <u>Other</u> Middle <u>Gentry</u> Last <u>Gentry</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginie.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Gentry</u>		14. MOTHER'S MAIDEN NAME <u>Elta. Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-20-2069</u>	
17. INFORMANT <u>Sister Mrs Rogers</u>		Address <u>4900 Randolph Rd. Rockville.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries multiple severe</u> DUE TO (b) <u>pedestrian struck by auto</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>walked on to highway in path of auto.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1030 a.m. 6/8 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>R. Gaithersburg Mont. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>6/9/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City or Town) (County) (State) <u>McGaheysville, Virginia</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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R. G. Gentry  
Ref. 22

June

W. W. Gentry

W. W. Gentry

USA

Virginia

Robert

Elio Gentry

Henry Gentry

Mrs. Gentry  
R. G. Gentry

No.

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R. G. Gentry  
Highway

John A. Gentry  
John A. Gentry

6/1/50

Chattanooga, Tennessee

Chattanooga, Tennessee

Chattanooga, Tennessee

Chattanooga, Tennessee

Chattanooga, Tennessee  
Chattanooga, Tennessee  
Chattanooga, Tennessee

Cleared with Medical Examiner  
Dr. Reap / m.r.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08365

CERTIFICATE OF DEATH

08356

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor Silver Spring</b> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery Generah Hospital</b>		d. STREET ADDRESS <b>1106 Ednor Rd.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Edith</b> First <b>Amelia</b> Middle <b>C.</b> Last <b>George</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/1886</b> 80.7 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years lost birthday) <b>80.7</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gaylord Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Cora Nobles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-07-4944</b>	
17. INFORMANT <b>Hospital Records, Olney, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL FAILURE</b> DUE TO <b>CHRONIC CONGESTIVE HEART FAILURE</b> 6 Mo (b) <b>ARTERIOSCLEROTIC HEART DIS</b> YRS (c) <b>PULMONARY EMPHYSEMA &amp; CHR. INANITION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA &amp; CHR. INANITION</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 1964</b> to <b>6/17/67</b> , that (I) (we) last saw the deceased alive on <b>6/15/67</b> , and that death occurred at <b>3:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Donald R. Lewis</b>		22b. DATE SIGNED <b>6/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis</b>		22d. ADDRESS <b>Medical Center, Olney, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Com.</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR <b>JUN 21 1967</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00380

STATEMENT OF DEATH

00380

00380

FOR MEDICAL EMPLOYMENT: Cdr. Transition

Acute Myocardial Infarct 2000  
Chronic Coronary Heart Disease  
Atherosclerotic Heart Dis 1/2

Robert D. Jones  
01/20/01

Dec 14 01  
01/17/01  
01/17/01

## CERTIFICATE OF DEATH

08366

08353

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>1 1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>8505 Flower avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marie Elizabeth Gernand</b>		4. DATE OF DEATH Month Day Year <b>June 6 19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-01</b> 9. AGE (In years last birthday) <b>65 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Heinrich Humburg</b>		14. MOTHER'S MAIDEN NAME <b>Katharina</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-30-627-1</b>	
17. INFORMANT <b>Patient's chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis + Coma</b> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myelonephritis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 19 67</b> to <b>June 6, 19 67</b> that (I) (we) lost saw the deceased alive on <b>June 5, 19 67</b> , and that death occurred at <b>4:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Boris Robkin</b>		22b. DATE SIGNED <b>June 6, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>BORIS ROBKIN, MD</b>		22d. ADDRESS <b>1019 Univ. Blvd, East</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Pharmington Rd. S. Geo. Md</b>
24. FUNERAL DIRECTOR <b>Arthur Tatters</b>		25a. REC'D BY REGISTRAR <b>PAUL J. JUDGE</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUN 9 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF DEBTS

03300

(42)

01230

0207

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1901

1902

1903

1904

1905

1906

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08367

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08359

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>10841 Childs Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PATRICK</u> Middle <u>Joseph</u> Last <u>Gibbons</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 26 1930</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Queens Fiberglass Co.</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Patrick Gibbons</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Rodgers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Korean</u>			
16. SOCIAL SECURITY NO. <u>578-34-7385</u>				17. INFORMANT <u>Mary Lou Gibbons</u> Address <u>10841 Childs Street Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary insufficiency</u> DUE TO (b) <u>coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u> <u>Bethesda, Maryland</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/26/67</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08368

08360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>-DC-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Chevy Chase -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 443	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5454 Wisconsin Ave Barlow Bldg</u>		d. STREET ADDRESS <u>1855 Colvert St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Stanley</u> First <u>Goldman</u> Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1931</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Herman Goldman</u>		14. MOTHER'S MAIDEN NAME <u>Tillie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose running from exhaust pipe to back window of car motor running</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:30 a.m. 6/1/1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Office Bldg.</u>		20f. (City or town) (County) (State) <u>Chevy Chase - Montgomery</u> <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>6/1/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Montefiore Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery County, Pa.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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M. W.

Carbon Monoxide Poisoning

12 - 6/11 - 67

Chapman

John M. Ball

6/1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08363

CERTIFICATE OF DEATH

08361

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		d. STREET ADDRESS <u>1213 Morningside Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First Middle Last <u>Goldovsky</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/12</u> 95 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rima GREENLAND</u> Address <u>R.D. Box 123 WALDORF, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>67</u> , to <u>6/18</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6/17</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/18/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>6-19-67</u>		<u>Lee's Crematory</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Washington D.C.</u>		<u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Frazier's</u>		25a. REC'D BY REGISTRAR <u>Charles J. [Signature]</u>	
ADDRESS <u>389 R. I. Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	
DATE <u>JUN 21 1967</u>			

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08311

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08370

08362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. Rockville</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodmont Country Club</u>		e. STREET ADDRESS <u>2801 New Mexico Ave - N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph. Lansburgh Goldsmith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Lansburgh Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles. Goldsmith.</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lansburgh.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-01-6942</u>	
17. INFORMANT <u>Jon. Englund</u>		18. ADDRESS <u>1540 Rockville Pike. Rockville, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4201</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>6/9/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Heb. Cong. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>		25. ADDRESS <u>3501-14th St. NW, Wash. DC, 20010</u>	
26. REC'D BY REGISTRAR <u>14 1967</u>		27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Washington D.C.

Montgomery

Washington

DC

R. Rockwell

2500 Pennsylvania Ave. NW

Woodmont Community Club

Zone 8

Ralph Randolph Goldsmith

May 2, 1977

M. W.

Washington D.C.

President Randolph Goldsmith

Minor Goldsmith

Charles Goldsmith

2-1-14-10

San Francisco 1977-1978

Colonial & Industrial Arts

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John D. Bull

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08371

# CERTIFICATE OF DEATH

08363

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA (RURAL)</u>			c. LENGTH OF STAY IN lb <u>76 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NAVAL HOSPITAL</u>				d. STREET ADDRESS <u>4400 LEE HIGHWAY APT. 301</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL CHRISTOPHER GOOD</u>				4. DATE OF DEATH Month Day Year <u>JUNE 20 19 67</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 OCTOBER 1945</u>		9. AGE (In years lost birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>FREEMONT, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DALE S. GOOD</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN PAVELLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>228-62-8650</u>		17. INFORMANT <u>DALE S. GOOD, 3 DENISE COURT, ST. JAMES, NEW YORK</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDESPREAD METASTASIS</u> <u>178X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NECROTIZING PERITONITIS SECONDARY TO INTESTIONAL STRANGULATION</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>5 APRIL</u> , 19 <u>67</u> , to <u>20 JUNE</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>20 JUNE</u> , 19 <u>67</u> , and that death occurred at <u>7:00 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Lawrence A. Jones</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>21 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence A. Jones, M. D.</u>				22d. ADDRESS <u>NAVAL HOSPITAL, BETHESDA, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>Charles A. Jones</u> DRIVE, ARLINGTON, VA. ARLINGTON FUNERAL HOME, 3901 NORTH FAIRFAX				25a. REC'D BY REGISTRAR <u>DATE JUN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

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Form with multiple sections and fields, including a large circular stamp in the center. The text is mirrored and difficult to read, but appears to be a standard administrative or legal form.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08372

CERTIFICATE OF DEATH

08364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Tb <u>26 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5617 Durbin Road</u>	
3. NAME OF DECEASED (Type or print) <u>Peter F Gordon</u>		4. DATE OF DEATH <u>June 21 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5-1917</u>
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Peter Gordon Company</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Blackstone - Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Lorinda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1918 WWI</u>		16. SOCIAL SECURITY NO. <u>379-12-3989A</u>	
17. INFORMANT <u>Mrs A. Gordon - above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm thoracic and abdominal aorta, ruptured</u> DUE TO (b) <u>arteriosclerosis.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/21/67</u> to <u>6/21/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> 19 <u>67</u> , and that death occurred at <u>8:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Brennan</u>		22b. DATE SIGNED <u>6-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. S. BRENNAN</u>		22d. ADDRESS <u>Cherry Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 27 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100-100

CHARTER OF DATES

08373

The first day of the month of  
October 1917  
at the City of New York  
in the County of New York  
before me, the undersigned  
Notary Public, personally  
appeared the said  
and acknowledged to me  
that he executed the foregoing  
instrument for the purposes  
and to the effect therein  
expressed.

Notary Public  
for the State of New York  
in and for the County of New York  
My Commission Expires  
October 1, 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified & approved

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08373  
CERTIFICATE OF DEATH  
08365

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>510 Kerwin Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gregory Gonthro</b>				4. DATE OF DEATH Month Day Year <b>June 12 19 67</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 4, 1916</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Novia Scotia, Canada</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>David Y. Gonthro</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth <del>McMullin</del> Mc Mullin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Elizabeth Gonthro</b>		Address <b>510 Kerwin Road Silver Spring, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>18 mos.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1966</b> , to <b>June 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3 1967</b> , and that death occurred at <b>2:31 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William F. Simpson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William F. Simpson, MD.</b>				22d. ADDRESS <b>6216 N.H. Ave RF.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 15, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b>				ADDRESS <b>8434 Georgia Avenue</b>		25. REG'D BY REGISTRAR <b>JUN 15 1967</b>	
26. FUNERAL HOME <b>Warner E. Humphrey, Inc.</b>				ADDRESS <b>Silver Spring, Md.</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08374

CERTIFICATE OF DEATH

08366

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>104 Park Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kenneth Paul Graham</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-07</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>America</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Lyman W. Graham</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Barbee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Patient's chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Viremia - Acute severe</b> DUE TO (b) <b>Acute Renal failure</b> DUE TO (c) <b>Severe Anemia - Otherwise Etiology?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Palsy; Secondary Anemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>May 15, 1967</b> , to <b>June 7, 1967</b> , that (2) (we) last saw the deceased alive on <b>June 7, 1967</b> , and that death occurred at <b>3:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Wilford D. Meyers MD.</b>		22b. DATE SIGNED <b>June 8, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilford D. Meyers MD.</b>		22d. ADDRESS <b>8323 Haddon Dr. Takoma Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rock Creek Cemetery</b>
24. FUNERAL DIRECTOR <b>Robert Waters</b>		25a. READ BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 12 1967</b>	

MEDICAL CERTIFICATION

03374

RECEIVED

03308

03308

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

08367

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: "Residence before admission") a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>00104 Cedar Lane</b>		d. STREET ADDRESS <b>104 CEDAR AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b>		Middle <b>W.</b>		Last <b>GRIFFITH</b>	
4. DATE OF DEATH <b>June</b>		Month <b>8</b>		Day <b>1967</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Oct 14 - 1908</b>		9. AGE (in years lost birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U S Government</b>		12. KIND OF BUSINESS OR INDUSTRY <b>III</b>		13. BIRTHPLACE (State or foreign country) <b>Laytonsville. Montg. Md.</b>	
14. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		15. FATHER'S NAME <b>Worthington Griffith</b>		16. MOTHER'S MAIDEN NAME <b>Lena Gloyd</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 2</b>		18. SOCIAL SECURITY NO. <b>577-28-0078</b>		19. INFORMANT <b>Jane C. Griffith. As #2</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary arteriosclerosis, severe</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b>		21. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
24. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
26. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		27. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
29. (City or town)		30. (County)		31. (State)	
32. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		33. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		34. ADDRESS (Street, city, town, or county) <b>6/8/67</b>	
35. ACTUAL SIGNATURE <b>John S. Ball</b>		36. EXAMINER'S NAME (Type) <b>John S. Ball</b>		37. DATE SIGNED <b>6/8/67</b>	
38. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		39. DATE THEREOF <b>6-10-67</b>		40. NAME OF CEMETERY OR CREMATORY <b>St Rose</b>	
41. LOCATION (City or Town) <b>Gaithersburg. Md.</b>		42. (County)		43. (State)	
44. FUNERAL DIRECTOR <b>Ernest C. Gartner. Gaithersburg. Md.</b>		45. ADDRESS		46. REC'D BY REGISTRAR <b>JUN 12 1967</b>	
47. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		48. (City or town)		49. (County)	

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Wentworth

Continued

104 Cedar Lane

John -

X

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BRITISH

Oct 14 1908

23

Myocardial Infarction

Coronary atherosclerosis, severe

X X X

X 6/8/07

John D. Bell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove dating papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08376						08368					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN ID <i>8 Month's</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				d. STREET ADDRESS <i>12608 Parkland Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll Hall Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Emmett Russell Hackworth</i>						4. DATE OF DEATH Month Day Year <i>June 19 1967</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 17, 1895</i>		9. AGE (in years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Watch maker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Watches</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George R. Hackworth</i>						14. MOTHER'S MAIDEN NAME <i>Elizabeth Updike</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>WWI</i>		17. INFORMANT <i>Emma H. Hackworth</i>		Address <i>12608 Parkland Drive Rockville, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis with left</i> <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Multiple Cerebral Thromboses since</i> DUE TO (c) <i>Cerebro Sclerosis chronic</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>March 1966</i> <i>Undetermined</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arterio-sclerosis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 27, 1964</i> to <i>June 19, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 16, 1967</i> , and that death occurred at <i>10:23</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>George L. Ball</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>June 19, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>						22d. ADDRESS <i>10620 Georgia Ave Silver Spring, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 22, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Prince Georges Co. Md</i>				
24. FUNERAL DIRECTOR <i>John B. Warner</i> <i>Warner E. Pumphrey, Inc.</i>						ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>John B. Warner</i>		25b. REGISTRAR'S SIGNATURE <i>John B. Warner</i>	
DATE <i>JUN 22 1967</i>						SIGNATURE <i>John B. Warner</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08377

CERTIFICATE OF DEATH

08369

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>151</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		d. STREET ADDRESS <b>10111 MCKENNEY AVE</b>	
3. NAME OF DECEASED (Type or print) <b>RUSSELL E. HAMILL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-95</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ADMINISTRATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VETERANS ADMIN.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES HAMILL</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE KILROY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES MAY 1941 - MAY 1945</b>		16. SOCIAL SECURITY NO. <b>77-10-1041A</b>	
17. INFORMANT <b>MARY GENAU HAMILL</b>		Address <b>24, b, d, above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> 465X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertension</b> (c) <b>possible pulmonary infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hr.</b> <b>8 hr.</b> <b>8 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>6/21</b> , 19 <b>67</b> , to <b>6/24</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>6/24</b> , 19 <b>67</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry W. Stout</b>		22b. DATE SIGNED <b>6/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY W. STOUT</b>		22d. ADDRESS <b>10011 GEORGIA AVE SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>27 JUNE 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON DC.</b>	
24. FUNERAL DIRECTOR <b>LINALDI FUNERAL HOME</b>		25a. READ BY REGISTRAR <b>20012</b>	
ADDRESS <b>7400 GEORGIA AVE, NW</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JUN 27 1967</b>			

08371

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DEPT. OF HEALTH

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10-10-1918

10-10-1918

Silver Spring

Silver Spring

Harry Cross Hospital 1011 McKenney Rd

Russell X E. Hawley

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W 3-15-22

08378

## CERTIFICATE OF DEATH

08370

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Robeson</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>61 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>Rural Route 2</b>	
3. NAME OF DECEASED (Type or print) <b>Daniel Monroe HARDIN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>06</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 8, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months <b>06</b> Days <b>06</b> Hours <b>06</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Fairmont, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Everett Hardin</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Graham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Billy E. Hardin, R.R.2, Fairmont, N.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>1810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO <b>transitional cell carcinoma of the bladder</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>5 April</b> , 19 <b>67</b> , to <b>6 June</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 June</b> , 19 <b>67</b> , and that death occurred at <b>2:10AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James L. Snyder</b>		22b. DATE SIGNED <b>6 June 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Snyder, LCDR MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		23d. LOCATION (City or Town) (County) (State) <b>Barnesville, North Carolina</b>	
24. FUNERAL DIRECTOR <b>Pearsons Funeral Home, 72 N. Washington Street, Falls Church, Virginia</b>		25a. REC'D BY REGISTRAR <b>JUN 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3014</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>432 Rosecroft Terr.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Anna Harmis</u>		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1874</u>
9. AGE (In years lost birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>19</u> Hours <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew N. Nazaranus</u>		14. MOTHER'S MAIDEN NAME <u>Louise Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>GEORGE W. WEISS</u>		Address <u>11623 34th Place, Beltonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>4200</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Uremic toxic infection</u> <u>② Anemia - mild</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs</u> <u>6-8 hrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>65</u> to <u>6-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-21</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>6-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>		22d. ADDRESS <u>BURTONSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-24-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W. W. Charles G. Quindt, Inc.</u>		25a. REC'D BY REGISTRAR <u>Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>		DATE <u>JUN 23 1967</u>	

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08380

## CERTIFICATE OF DEATH

08372

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rockville</b> c. LENGTH OF STAY IN lb <b>151</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10735 Hunting Lane</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rockville</b> d. STREET ADDRESS <b>10735 Hunting Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry W. Harmon</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1904</b>
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>29</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Harmon</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Butt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW1</b>		16. SOCIAL SECURITY NO. <b>212-14-6629</b>	
17. INFORMANT <b>Preston Butt- Hunting Hill, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO (b) <b>anemia</b> DUE TO (c) <b>Possible malignancy, not defined at</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>6 months</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>V.A. Hospital Bay 1967</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 <b>June 13 1967</b> , to <b>June 19 1967</b> , that (I) (we) last saw the deceased alive on <b>June 13 1967</b> , and that death occurred at <b>GA. Md.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W.A. Linthicum</b>		22b. DATE SIGNED <b>6/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Linthicum</b>		22d. ADDRESS <b>110 S. Washington St., Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/22/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08382

CERTIFICATE OF DEATH

08374

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4504 Maple Avenue</b>		d. STREET ADDRESS <b>4504 Maple Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE E. HARRIS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		12. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
13. FATHER'S NAME <b>Charles Townsend Harris</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Bronski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>2059 N.H. Ave, N.W.</b>	
17. INFORMANT <b>Mrs. Earl P. Clark</b>		18. ADDRESS <b>Washington, D. C.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>8 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive cardiovascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1, 1957</b> to <b>June 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 27, 1967</b> , and that death occurred at <b>9:50 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Coale</b>		22b. DATE SIGNED <b>6-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. ADDRESS <b>4429 Bradley Lane Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crematory</b>		23b. DATE THEREOF <b>6-2-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

DEPARTMENT OF HEALTH

03232

Montgomery

Birth date

2504 Maple Avenue

Marriage

Female white

Montgomery

Charles Frederick Harris

Caroline Bennett

Mr. Carl E. Clark

New York

July 20, 1922

Married

June 1, 1922

2504 Maple Avenue

Female

Birth date

Montgomery

Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MONTGOMERY MARYLAND														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>					c. LENGTH OF STAY IN 1b <b>8 Months</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>14710 New Hampshire Ave.</b>					e. STREET ADDRESS <b>14710 NEW HAMPSH. AVE.</b>									
3. NAME OF DECEASED (Type or print) <b>ELSIE MAY HARRISS</b>					4. DATE OF DEATH Month <b>6</b> Day <b>12</b> Year <b>1967</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/20/1897</b>		9. AGE (In years last birthday) <b>69</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>POTOMAC, MONT. CO MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>								
13. FATHER'S NAME <b>JOSEPH WINDSOR</b>					14. MOTHER'S MARRIAGE NAME <b>ODIE HALL</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>—</b>					17. INFORMANT Address <b>DAUGHTER (O. COLLINS) SAME</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X ACUTE MYOCARDIAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <b>January 1967</b> to <b>6/12/1967</b> , that (I) (we) last saw the deceased alive on <b>May 19 1967</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Donald R. Lewis MD</b>					22b. DATE SIGNED <b>6/12/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>DONALD R. LEWIS</b>					22d. ADDRESS <b>700 CLOVERLY ST. SILVER SPRING MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>6-15-67</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Meth. Ch. Cem.</b>				
23d. LOCATION (City, town or county) (State) <b>Potomac, Maryland</b>														
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUN 16 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>				

02003

Montgomery

Silver Spring

Elise

May

Harris

7/1/1897

Female White

x

Horse Kept

Don't know

1410 New Hampshire Ave

Silver Spring Md

6 12 51

Patent, Mont. Co. Md. U.S.A.

Oldie Hair

Daughter (O. Gorman) same

Acute Myocardial Disease  
Arteriosclerotic Hypertensive Heart  
Concentric Arteriosclerosis

Donald F. Lewis MD

Donald R. Lewis MD

James E. Lewis MD

Silver Spring Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08383

# CERTIFICATE OF DEATH

08375

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY <b>C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BETHESDA</b>			c. LENGTH OF STAY IN 1b <b>35 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>473</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL, BETHESDA, MD. 20014</b>				d. STREET ADDRESS <b>1530 29th ST. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>A.</b> Last <b>HART</b>				4. DATE OF DEATH Month <b>22</b> Day <b>JUNE</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 SEPT 1894</b>		9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILITARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USMC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUTHBERT, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL BEALL HART</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE SMITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I &amp; II</b>		16. SOCIAL SECURITY NO. <b>578-52-4656</b>		17. INFORMANT Address <b>KATHERINE HART 1530 29th ST N.W., W.D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMPHYSEMA</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>19 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>19 MAY</b> , 1967, to <b>22 JUNE</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>22 JUNE 1967</b> , and that death occurred at <b>1:20PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>22 JUNE 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL CDR MC USN</b>				22d. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD 20014</b>			
23a. BURIAL, CREMATION, etc. (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-26-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, ARLINGTON, VA.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>JOS. GAWLER &amp; SONS WASHINGTON, D.C.</b>				25a. REC'D BY REGISTRAR <b>JUN 29 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



08384

## CERTIFICATE OF DEATH

08377

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>8722 Colesville Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>RITA</u> Middle <u>M</u> Last <u>HENKELS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	9. AGE (In years last birthday) <u>66</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Henkels</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Abbie V. Henkels</u>		Address <u>8722 Colesville Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>4201</u> DUE TO <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>by</u> <u>myocardial fibrosis</u> DUE TO (c) <u>coronary atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>0021</u> <u>Chronic Bronchitis Pulmonary Tuberculosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10, 1967</u> , to <u>JUNE 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 7, 1967</u> , and that death occurred at <u>9:10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u>		22b. DATE SIGNED <u>JUNE 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN M.D.</u>		22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>	
ADDRESS <u>48434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1990

4860

2  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08385

CERTIFICATE OF DEATH

08378

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>1956 Fendall Street, S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Franklin</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 April 1954</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR Months <u>20</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Henry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fennell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema &amp; Ventricular Fibrillation</u> DUE TO (b) <u>Cardiomegaly</u> DUE TO (c) <u>Muscular Dystrophy vs. Polymyositis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 months</u> <u>13 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>19 June</u> , 19 <u>67</u> , to <u>20 June</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 June</u> , 19 <u>67</u> , and that death occurred at <u>2:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Griggs</u>		22b. DATE SIGNED <u>20 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Griggs, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Keathern Cemetery Harrell, N.C.</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Montgomery Bros Inc 719 Kennedy St NW</u>		25a. REC'D BY REGISTRAR <u>J Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 26 1967</u>	

03330

03330

THE CITY OF BOSTON, MASSACHUSETTS, DO hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the City Clerk.

WITNESSED my hand and the seal of the City of Boston, this 1st day of May, 1900.

CITY CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08386

CERTIFICATE OF DEATH

08379

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		d. STREET ADDRESS <u>1900 Virginia Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Jo Ann</u> Middle <u>Lee</u> Last <u>Hess</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1932</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>34</u> yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Alice Wood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-28-7139</u>	
17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial pressure</u> DUE TO (b) <u>Intracerebral metastasis</u> DUE TO (c) <u>Malignant Melanoma</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1909</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 Weeks</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>June 8</u> , 19 <u>67</u> , to <u>June 15</u> , 1967, that <u>(X)</u> (we) last saw the deceased alive on <u>June 15</u> , 19 <u>67</u> , and that death occurred at <u>2:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent T. DeVita, Jr.</u>		22b. DATE SIGNED <u>15 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent T. DeVita, Jr. MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/17/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAWN MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN, WASH.CO. MD.</u>	
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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[Faint, mostly illegible text covering the main body of the document, possibly a letter or report. Some words like "RECEIVED" and "08330" are visible.]

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## CERTIFICATE OF DEATH

08380

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5813 Green Tree Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edgar Flanoy Hicks Jr.</b> First Middle Last 4. DATE OF DEATH <b>June 11 19 67</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Cauc</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov. 7 1907</b> 9. AGE (In years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineering</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Ch./Eng.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Jackson, Tennessee</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edgar Flanoy Hicks Sr.</b> 14. MOTHER'S MAIDEN NAME <b>Willie Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.II</b> 16. SOCIAL SECURITY NO. <b>535 36 1353</b> 17. INFORMANT <b>Jean R. Hicks Bethesda, Maryland</b> Address <b>5813 Green Tree Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infraction, Acute</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1201</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>10 June, 19 67</b> , to <b>11 June, 19 67</b> , that (I) (we) lost saw the deceased alive on <b>11 June, 19 67</b> , and that death occurred on <b>10 26 a.m.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Jack E. Zimmerman</b> 22c. PHYSICIAN'S NAME (Type) <b>Jack E. Zimmerman M.D.</b>		22b. DATE SIGNED <b>12 June 1967</b> 22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>6/15/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore, Maryland</b> 23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR <b>Jos. Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., N.W., Washington, D.C.</b> 25a. REC'D BY REGISTRAR <b>JUN 19 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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COMMUNIST ORGANIZATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

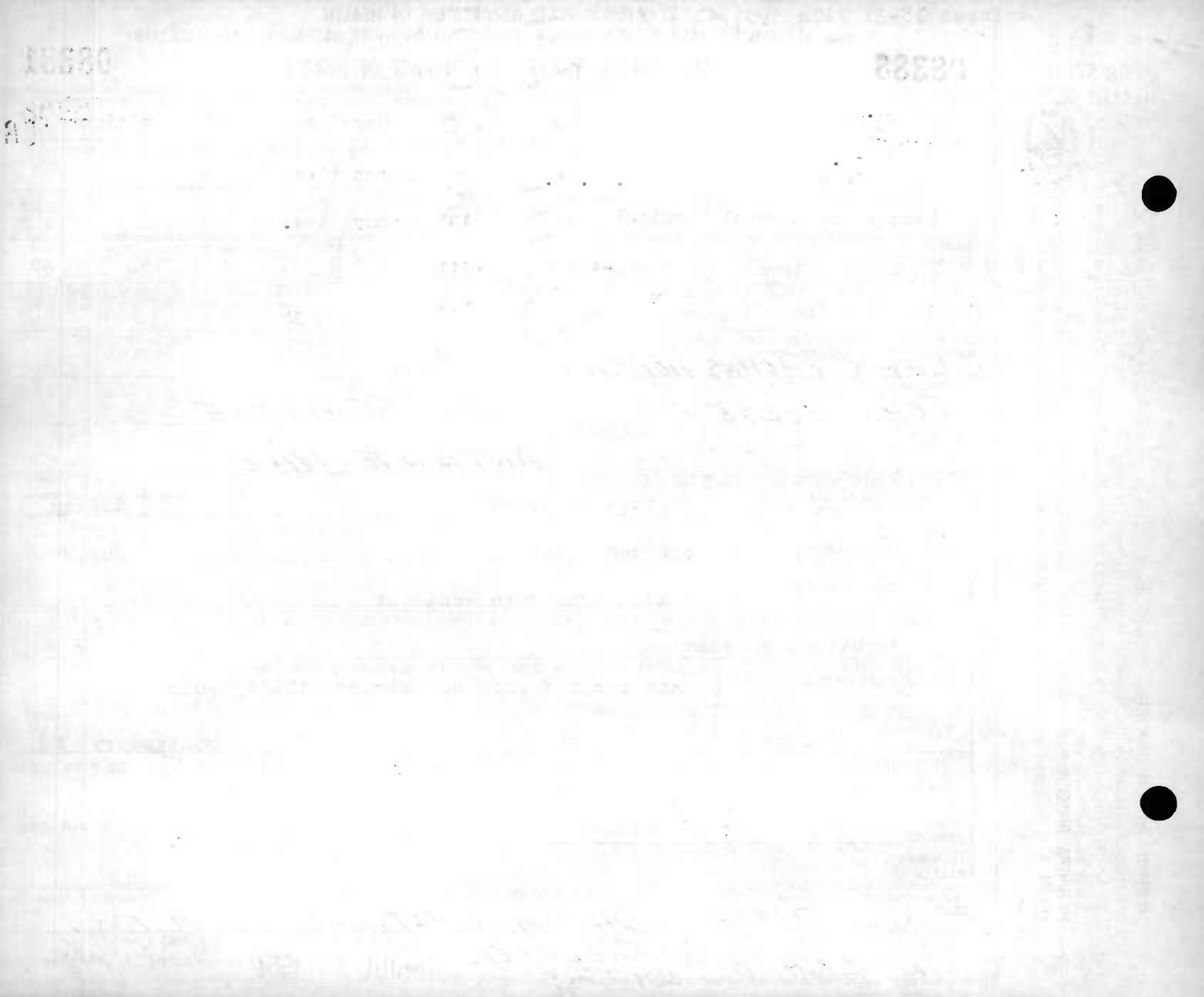
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>132 Newburg Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Catherine</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>6</b> Day <b>28</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/3/13</b>	
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK, JOHN'S HOPKINS</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>JOHN HOLSEY</b>				14. MOTHER'S MAIDEN NAME <b>ROSE SCHINDLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>ARTHUR E. HILL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8234</b> IMMEDIATE CAUSE (a) <b>Rupture of heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>crushed chest</b> DUE TO (c) <b>trauma from auto accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Barbiturate sedation</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran car off road and struck utility pole</b>			
20c. TIME OF INJURY Month, Day, Year <b>510</b> Hour a.m. <b>28 June 67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Olney Montgomery Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John B. Ball</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b></b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/29/67</b>			
				Address (Street, city, town, or county) <b></b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>E. S. MACNABB</b>				25a. REC'D BY REGISTRAR <b>301 FREDERICK</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>JUL 3 1967</b>			

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN 1b <b>154</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26134 Ridge Rd.</b>		d. STREET ADDRESS <b>26134 Ridge Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Grover</b> Middle <b>--</b> Last <b>Hilton</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1886</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Damascus, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Brice Hilton</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-2293</b>	
17. INFORMANT <b>Ernest G. Hilton, Damascus, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Thrombi</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arteriosclerotic Cardio-Vascular Disease.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19 <b>1967</b> , to <b>June 5, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>June 5, 1967</b> and that death occurred at <b>6 P M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>M. McKendree Boyer</i>		22b. DATE SIGNED <b>June 6, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M.D.</b>		22d. ADDRESS <b>9701 Church Street Damascus, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Damascus, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 12 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN <b>2 days/20 1/2 hr.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b> First <b>Piper</b> Middle <b>Holler</b> Last <b>croft</b>				4. DATE OF DEATH <b>June 26, 1967</b> Month <b>June</b> Day <b>26</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-9-86</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Ky.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Augustus Piper</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Hammond</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>- - - -</b>	
16. SOCIAL SECURITY NO. <b>- - - -</b>		17. INFORMANT <b>Hospital Records</b>		18. ADDRESS <b>7600 Carroll Ave.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>4500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of Left wrist</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Fell on left arm</b>					
20c. TIME OF INJURY Month, Day, Year <b>9</b> Hour a.m. <b>June 13</b> 19 <b>67</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Union Springs N.Y.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John W. Ball</b> M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)		22. DATE SIGNED <b>6/26/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Glen Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aurora, N.Y.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisconsin Ave. N.W., Wash. DC.</b>		25a. REC'D BY REGISTRAR <b>JUN 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

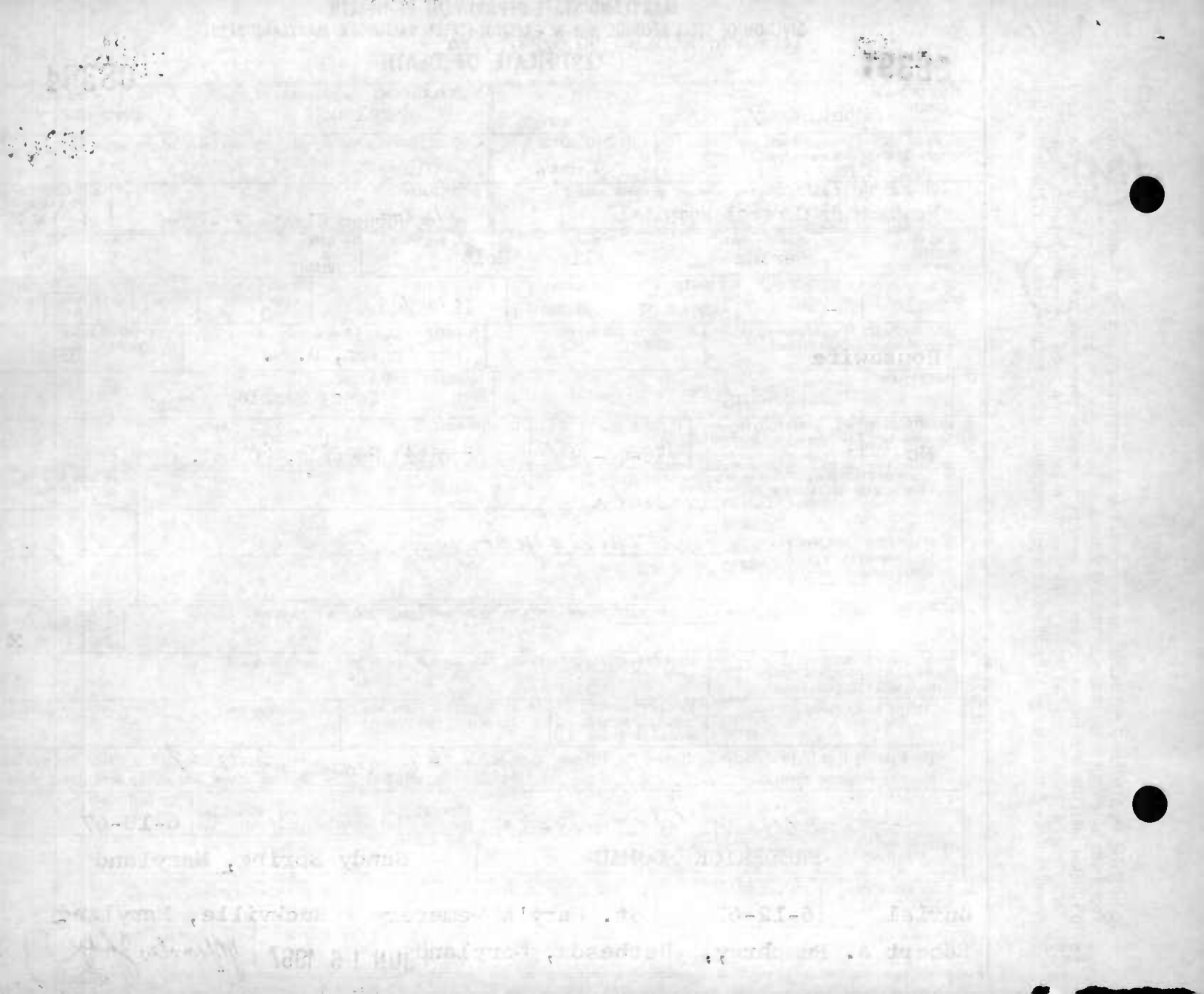
08391

08384

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. STREET ADDRESS <b>c/o Gordon Ulmstead - Son</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Alice Holt</b>		4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/86</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph King</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Parsley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-48-6930</b>	
17. INFORMANT <b>Hospital Records, Olney, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6000 Uremia</b> DUE TO (b) <b>Chronic pyelonephritis</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-2-67</b> , 19, to <b>6-9-67</b> , 19, that (I) (we) last saw the deceased alive on <b>6-9-67</b> , 19, and that death occurred at <b>9 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Frederick Mooman</b> M.D.		22b. DATE SIGNED <b>6-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK MOOMAU</b>		22d. ADDRESS <b>Sandy Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08392

CERTIFICATE OF DEATH

08385

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN TB <b>2 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>Box 192, Route 2</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WASHINGTON HOWES</b>		4. DATE OF DEATH Month Day Year <b>6 21 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-91</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JAMES R. HOWES</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA GREEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217 32 3586</b>	
17. INFORMANT <b>MEDICAL RECORD DEPT.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Congestive Heart Failure (Acute &amp; Chronic)</b> DUE TO (b) <b>① A.H.D. ② Aplastic Anemia (Reversed) OK</b> DUE TO (c) <b>Polycthemia Vera</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Polycthemia Vera</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 to <b>1967</b> , that (I) (we) last saw the deceased alive on <b>6-21-1967</b> , and that death occurred at <b>2:10 PM</b> , from causes on and the date stated above.			
22a. SIGNATURE <b>Jack Schumacher M.D.</b>		22b. DATE SIGNED <b>6-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 23 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>	23d. LOCATION (City or Town) (County) (State) <b>Laytonsville Mont. Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber Laytonsville Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08393

CERTIFICATE OF DEATH

08388

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, RURAL</b>		c. LENGTH OF STAY IN 1b <b>67</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PORT DEPOSIT</b>		d. STREET ADDRESS <b>RT#1, BOX 210</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US NAVAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLIVER</b> Middle <b>(NMN)</b> Last <b>HUDSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10 1916</b>
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ANNA MEAUX</b>		Address <b>423 ASH STREET LEXINGTON, KY.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKIN'S DISEASE</b> 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 27, 1967</b> , to <b>JUNE 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 2, 1967</b> , and that death occurred at <b>4:35 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. E. ZIMMERMAN</b> <i>J. E. Zimmerman</i>		22b. DATE SIGNED <b>JUNE 3 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>US NAVAL HOSPITAL, BETHESDA, MD.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT <b>BURIAL</b>		23b. DATE THEREOF <b>6-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLDALE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>DANVILLE KY.</b>	
24. FUNERAL DIRECTOR <b>R. A. PUMPHREY FUNERAL HOME</b>		ADDRESS <b>7557 WISCONSIN RD BETHESDA, MD</b>	
25a. REGISTRAR <b>JUN 8 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Alfred</u> Last <u>Hufford</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 August 1948</u>
9. AGE (In years lost birthday) <u>18</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond P. Hufford</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Earhart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Hodgkin's Disease</u> DUE TO (c) <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pancytopenia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o.m.</u> Month, Day, Year p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4 May</u> , 19 <u>67</u> , to <u>6 June</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6 June</u> 19 <u>67</u> , and that death occurred at <u>11:05M</u> , from causes on and the date stated above.			
22a. SIGNATURE <u>Jerry L. Spivak</u>		22b. DATE SIGNED <u>June 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jerry L. Spivak, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>	23d. LOCATION (City or Town) (County) (State) <u>Cresson, Cambrice Co., Pa.</u>
24. FUNERAL DIRECTOR <u>Tyson Heeler Funeral Home-1351 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1967</u>	
ADDRESS <u>Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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REPORT OF DEATH

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REPORT OF DEATH  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Signature: [illegible]  
Occupation: [illegible]  
Address: [illegible]  
City: [illegible]  
State: [illegible]  
County: [illegible]  
Zip: [illegible]

## CERTIFICATE OF DEATH

08388

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>1007 Kenneth Street</b>	
3. NAME OF DECEASED (Type or print) <b>Jon Hudson HULME</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1920</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USAF Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Major</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Atlanta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Hulme</b>		14. MOTHER'S MAIDEN NAME <b>Jimmie Liela Upchurch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1941-1965</b>		16. SOCIAL SECURITY NO. <b>259-03-4660</b>	
17. INFORMANT <b>S.W., Atlanta</b>		Address <b>Georgia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esoph</b> <b>Esophageal varices Laennec's Cirrhosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from <b>June 7</b> , 19 <b>67</b> , to <b>June 13</b> , 19 <b>67</b> , that (it) (we) last saw the deceased alive on <b>June 13</b> , 19 <b>67</b> , and that death occurred at <b>6:25 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>W. J. Bouty</i>		22b. DATE SIGNED <b>14 June 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. BOUTY, CDR MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/16/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Marietta National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Marietta, Georgia</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home</b>		25a. REC'D BY REGISTRAR <b>LaPlata, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>JUN 16 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00308

00308

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of registrar		14. Name of informant		15. Name of physician		16. Name of hospital	
17. Name of funeral home		18. Name of cemetery		19. Name of burial place		20. Name of interment place	
21. Name of crematorium		22. Name of crematorium		23. Name of crematorium		24. Name of crematorium	
25. Name of crematorium		26. Name of crematorium		27. Name of crematorium		28. Name of crematorium	
29. Name of crematorium		30. Name of crematorium		31. Name of crematorium		32. Name of crematorium	
33. Name of crematorium		34. Name of crematorium		35. Name of crematorium		36. Name of crematorium	
37. Name of crematorium		38. Name of crematorium		39. Name of crematorium		40. Name of crematorium	
41. Name of crematorium		42. Name of crematorium		43. Name of crematorium		44. Name of crematorium	
45. Name of crematorium		46. Name of crematorium		47. Name of crematorium		48. Name of crematorium	
49. Name of crematorium		50. Name of crematorium		51. Name of crematorium		52. Name of crematorium	
53. Name of crematorium		54. Name of crematorium		55. Name of crematorium		56. Name of crematorium	
57. Name of crematorium		58. Name of crematorium		59. Name of crematorium		60. Name of crematorium	
61. Name of crematorium		62. Name of crematorium		63. Name of crematorium		64. Name of crematorium	
65. Name of crematorium		66. Name of crematorium		67. Name of crematorium		68. Name of crematorium	
69. Name of crematorium		70. Name of crematorium		71. Name of crematorium		72. Name of crematorium	
73. Name of crematorium		74. Name of crematorium		75. Name of crematorium		76. Name of crematorium	
77. Name of crematorium		78. Name of crematorium		79. Name of crematorium		80. Name of crematorium	
81. Name of crematorium		82. Name of crematorium		83. Name of crematorium		84. Name of crematorium	
85. Name of crematorium		86. Name of crematorium		87. Name of crematorium		88. Name of crematorium	
89. Name of crematorium		90. Name of crematorium		91. Name of crematorium		92. Name of crematorium	
93. Name of crematorium		94. Name of crematorium		95. Name of crematorium		96. Name of crematorium	
97. Name of crematorium		98. Name of crematorium		99. Name of crematorium		100. Name of crematorium	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
ALBANY, N. Y.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08389

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4903 Edgemoore Lane</u>		d. STREET ADDRESS <u>4903 Edgemoore Lane</u>	
3. NAME OF DECEASED (Type or print) <u>James Earl Hummer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16, 1900</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consultant</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Walter Hummer</u>		14. MOTHER'S MAIDEN NAME <u>Lula</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>718-10-6064</u>	
17. INFORMANT <u>Wife</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4221</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>6/2/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>6/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Pk. Geo. Co., Md</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

JUN 5 1967

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Montgomery

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M. W.

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June 10, 1890

Washington D.C.

Walter H. Hume

Lot 1

No.

W.P.

Comptroller of the Treasury

Carl's Viceroy District

John's Ball

6/15/90

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08397

08390

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>			c. LENGTH OF STAY IN 1b <b>15, 1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DEXX D.O.A. Montgomery Co., Gen. Hosp.</b>				d. STREET ADDRESS <b>7332 MUNCASTER MILL ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELENA M. Husemen</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 4, 1891</b>	
				9. AGE (In years lost birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John O. Humphreys</b>				14. MOTHER'S MAIDEN NAME <b>Millie Ann Stone</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEDICAL RECORDS - MONTGOMERY GEN. HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO (b) <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				22. DATE SIGNED <b>6/19/1967</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 22nd, 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oxon Hill, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>				25a. REC'D BY REGISTRAR <b>JUN 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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08398

## CERTIFICATE OF DEATH

08391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1531	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1900 Lyttonsville Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Hyman</u> Last <u>Hyman</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/07</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>MAX HECKLEMAN</u>	
14. MOTHER'S MAIDEN NAME <u>LENA ? ? ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>578-05-5581</u>		17. INFORMANT <u>Mrs. Myra Wright</u> Address: <u>2208 Ellis St Silver Spring, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic &amp; Renal Insufficiency</u> DUE TO (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>6 months</u> <u>6 + months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>67</u> , to <u>June 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>67</u> , and that death occurred at <u>5:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen MD</u> M.D.		22b. DATE SIGNED <u>June 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, MD</u>		22d. ADDRESS <u>1806 SPRING ST. MD. SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WATKINS MEMORIAL PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>
24. FUNERAL DIRECTOR <u>Soldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4217-94 at 7:10</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 5 1967</u>	

19580

82880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08392 Item #8 Film #G390 6/23/67										
08392										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>453 WALKER AVE. SE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>V.</u> Last <u>Jackson</u>					4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/1924</u>		9. AGE (In years last birthday) <u>42</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>ARMY-NAVY-Club</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Adenocarcinoma of Breast</u> (c) <u>2 yrs.</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>6/10</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>6/10</u> , 19 <u>67</u> , and that death occurred at <u>1:20 AM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>G Leonard Gled</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/11/67</u>			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>			23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR <u>JOHN T. RHINES FUNERAL HOME 3015 12 ST. N. E.</u>				ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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## CERTIFICATE OF DEATH

08393

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (rural)</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DANVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>BOX 192</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RANDALL</b> Middle <b>JACOBS</b> Last				4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 DECEMBER 1885</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>DANVILLE, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVY</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>DANVILLE, PENNSYLVANIA</b>	
13. FATHER'S NAME <b>WILLIAM FREDERICK JACOBS</b>				14. MOTHER'S MAIDEN NAME <b>JANE MCCOY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1903-1953</b>				16. SOCIAL SECURITY NO. <b>172-30-6270</b>		17. INFORMANT <b>MARY JANE JACOBS, 2416 42ND AVE, EAST SEATTLE WASHINGTON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of bladder</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>14 JUNE</b> , 19 <b>67</b> , to <b>19 JUNE</b> , 19 <b>67</b> , that (b) (I) (we) last saw the deceased alive on <b>19 JUNE</b> , 19 <b>67</b> , and that death occurred at <b>1:15 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Laurence G. Jones</i>				22b. DATE SIGNED <b>19 June 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>L.A. JONES</b>	
22d. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>June 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VA.</b>	
24. FUNERAL DIRECTOR <b>N.W., WASHINGTON D.C.</b>				25a. REC'D BY REGISTRAR <b>JUN 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. FUNERAL HOME <b>W.W. CHAMBERS, FUNERAL HOME, 1400 CHAPIN ST.</b>							

5068

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## CERTIFICATE OF DEATH

08394

08401

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10200 Hatherleigh Road</b>		d. STREET ADDRESS <b>10200 Hatherleigh Road</b>	
3. NAME OF DECEASED (Type or print) <b>First Edward Middle E. Last Jerome</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 July 1917</b>
9. AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR Months <b>0</b> Ooys <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Communications Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Phone</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter F. Jerome</b>		14. MOTHER'S MAIDEN NAME <b>Kay Earl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>042-07-2198</b>	
17. INFORMANT <b>Evelyn A. Jerome-Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO (b) <b>acute myocardial infarction</b> OUE TO (c) <b>arteriosclerotic heart disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 hrs</b> <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>June 30, 1967</b> , that (II) (we) last saw the deceased alive on <b>June 15, 1967</b> and that death occurred at <b>8:50 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Wilfred R. Ehrmantrout</b>		22b. OATE SIGNED <b>6/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantrout</b>		22d. ADDRESS <b>11125 Rockville Pike, Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/3/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b>		25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08080

CERTIFICATE OF DEATH

10080

COMMON LINE

Johnson, Mrs, Elizabeth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08402				Items #8 & 9 Film #0390 6/25/67				08395			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall Sanitarium</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>F.</b> Last <b>Johnson</b>						4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>1967</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-9-1887/ 1886</b>		9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Berkelbach</b>						14. MOTHER'S MAIDEN NAME <b>Caroline Fowler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Edith Richey</b>			Address <b>Washington, D.C.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis, especially cerebral</b> 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral</b> (c) <b>2 months</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute cystitis, severe</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>August, 1966</b> , to <b>June 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 31, 1967</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Bennet A. Porter, Jr.</b> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <b>June 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr. M.D.</b>						22d. ADDRESS <b>9301 Coleville Rd., Silver Spring Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Hyattsville, Md.</b>			
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>						ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08403

08396

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Wash D.C.</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>		d. STREET ADDRESS <b>2929 Conn. Ave N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Glady's Noble Johnson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29-1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Noble</b>		14. MOTHER'S MAIDEN NAME <b>Frances E. Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT (Last name) <b>FRANK E. JOHNSON JR.</b>		Address <b>3801 Conn. Ave. Wash. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> DUE TO (b) <b>Arteriosclerotic heart disease with</b> DUE TO (c) <b>old healed anterior wall infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1945</b> , 19 <b>to June 1</b> , 1967, that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 31</b> , 1967, and that death occurred at <b>11:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arnold McNitt</b>		22b. DATE SIGNED <b>June 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARNOLD MCNITT, M.D.</b>		22d. ADDRESS <b>1835 Eye St. N.W. DC.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/3/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, MD</b>
24. FUNERAL DIRECTOR <b>PER. Thomas M. Hysong</b>		25a. REC'D BY REGISTRAR <b>WASH-D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 5 1967</b>	

03300

03300

Myocardial infarction, acute  
Coronary artery disease with  
old healed anterior wall infarction

May 31, 67

General Mr. Mitt

1965 by Dr. K. H. B.

June 1, 67

June 1, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

CORRECTED COPY FOLLOWING COMPLETED AUTOPSY REPORT

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
8404										
CERTIFICATE OF DEATH										
08397										
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN lb <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> <b>15.1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>					d. STREET ADDRESS <b>3010 Norbeck Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Virginia</b> Last <b>Johnson</b>					4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>2-23-87</b>		9. AGE (In years last birthday) yrs. <b>80</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Charles Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Laurea Owens</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>			Address <b>Olney, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION, TERM.</b> DUE TO <b>194X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY METASTASIS</b> DUE TO <b>CARCINOMA, THYROID, FOLLICULAR</b> (c) <b>YES.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 Yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>A.S.C.V.D. OLD INFARCT MYOCARDIUM</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>3 Mar, 1967</b> to <b>6/20, 1967</b> , that (1) (we) last saw the deceased alive on <b>6/19, 1967</b> , and that death occurred at <b>6:20 PM</b> , from causes and on the date stated above.										
22a. SIGNATURE <b>D. R. Lewis</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis, M.D.</b>					22d. ADDRESS <b>700 Cloverly St., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SANDYSPRING CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>SANDY SPRING, MONTG. MD.</b>			
24. FUNERAL DIRECTOR <b>Robert L. Snowden, Rockville, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>June 27, 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

Film # 392- 9/18/67. MB.

This is a corrected certificate & replaces original.

Cause of death completely changed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #3 & 14 Film #G391 7/27/67 ph									
08405 CERTIFICATE OF DEATH 08398									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN lb <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>					d. STREET ADDRESS <b>3705 Dunlop Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary</b> First <b>Jacqueline</b> Middle <b>JOHNSTON</b> Last			4. DATE OF DEATH <b>June</b> Month <b>26</b> Day <b>19</b> Year <b>67</b>			9. AGE (In years last birthday) <b>52</b> yrs.			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>March 10, 1915</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William S. Clark</b>					14. MOTHER'S MAIDEN NAME <b>Mary John Hoar</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>023-10-9155</b>		17. INFORMANT <b>Chevy Chase</b> Address <b>Md.</b> <b>Mr. Robert Johnston, 3705 Dunlop Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUPPURATIVE TRACHEOBRONCHITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RECURRENT EPIDERMAL CARCINOMA</b> DUE TO <b>OF PHARYNX INVASION OF CRANIUM</b> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>June 22, 1967</b> , to <b>June 26, 1967</b> that (4) (we) last saw the deceased alive on <b>June 26, 1967</b> , and that death occurred at <b>730A</b> M, from causes on and on the date stated above.									
22a. SIGNATURE <b>Hugh O. de Fries</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>June 26, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Hugh O. de Fries</b>					22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>6-29-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., N.W., Washington, D. C.</b>					25a. REC'D BY REGISTRAR DATE <b>JUN 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08406 CERTIFICATE OF DEATH 08599											
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			151			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>12510 Littleton St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wong</u> Middle <u>Shee</u> Last <u>JOK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>Yellow</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>4-20-99</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>China</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Gordon J. Tong - Same as #2</u>		Address <u>-</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse peritonitis</u> 5401 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Perforated marginal ulcer (gastric)</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> , 19 <u>67</u> , to <u>June 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 17</u> , 19 <u>67</u> , and that death occurred at <u>0137</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. William Marcus M.D.</u>		22b. DATE SIGNED <u>6-18-67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. William Marcus</u>		22d. ADDRESS <u>10620 Georgia Avenue, Silver Spring, Md.</u>		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. OIREDOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Memo. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Hvattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>			
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. NE Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S DATE <u>JUN 21 1967</u>							

00100

June 18 67

See General Home 100 4th St. NE Wash. D. C. JUN 11 1967  
and 1. 6-9-67 Geo. Wash. Home, Wash. D. C. 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2a,b,c & d File #G380 6/22/67 pc

08407

CERTIFICATE OF DEATH

08408

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robertson Valley N.H.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynchburg 151</u> d. STREET ADDRESS <u>Robertson Valley N.H.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Franklin</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u> 9. AGE (In years last birthday) <u>36</u> yrs. IF UNDER 1 YEAR Months Ooys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (County & State, or foreign country) <u>?</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>?</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-14-1047</u> 17. INFORMANT <u>Hosp. Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x cerebral Infarction</u> DUE TO (b) <u>cerebral Thrombosis</u> DUE TO (c) <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Pyelonephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/27/1967</u> to <u>6/8/1967</u> that (I) (we) last saw the deceased alive on <u>6/7/1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		22b. DATE SIGNED <u>6/8/67</u> 22d. ADDRESS <u>Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Potters Field</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler - 1331 Rockville Pike</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

50130

50130

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "specimen" and "number" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

Item 21 Film 390 7-7-67 am		MARYLAND STATE DEPARTMENT OF HEALTH	
08408		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Item #1c Film #G390 7/6/67 pc		08401	
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
c. LENGTH OF STAY IN lb 30 days		d. STREET ADDRESS 5825 Colfax Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred Elizabeth Kearney		4. DATE OF DEATH June 22 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1906	
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Ives		14. MOTHER'S MAIDEN NAME Mary Virginia Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Md. 20014		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO (b) Acute tubular necrosis DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 23 June 19 67, to June 22 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 22 19 67, and that death occurred at 9:05 AM, from causes and on the date stated above.			
22a. SIGNATURE Dr. Charles L. Vogel		22b. DATE SIGNED 22 June 1967	
22c. PHYSICIAN'S NAME (Type) Charles L. Vogel, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/67	
23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Alexandria, Virginia	
24. FUNERAL DIRECTOR W. A. Morris		25a. REC'D BY REGISTRAR 3901 No. Fairfax Dr. Arlington, Virginia 22203	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 26 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08403

08402

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>6122 Yellowstone Drive</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frances</u> First <u>O.</u> Middle <u>Keesling</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1904</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Clem Sween</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle O. Strander</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hugh Keesling</u> Address <u>8208 Jeb Stewart Road Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Congestive Heart Failure</u> DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Metastatic Carcinoma of the stomach</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 mos.</u> <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1967</u> to <u>June 5, 1967</u> ; that (I) (we) last saw the deceased alive on <u>June 5, 1967</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William F. Morrissey</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Morrissey</u>				22d. ADDRESS <u>Arlington</u>		<u>Virginia</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Carter</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08803

08803

General, June 1, 1907, Fort Lincoln, Oregon, 10 miles north of Co., Mo.

Dear Sir: I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
John W. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.  
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Leaved with Medical Examiner

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08410

08403

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>TWENTY YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOME; - 9300 PINEY BRANCH RD. APT 303.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>9300 PINEY BRANCH RD. APT 303</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>MARIE LOUISE KELLEY</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12</b> Year <b>1967</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 13, 1914</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>		IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUDGET TECHNICIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT</b>				11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOHN FITZGERALD</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Juenemann</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-383-181</b>				17. INFORMANT Address <b>HUSBAND - JOHN KELLY</b> <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(2) Pulmonary Emphysema</b>												INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>approx 10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>		Month, Day, Year <b>1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>SILVER SPRING, M.D.</b>		(County)		(State)		21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>approx.</b> <b>1967</b> to <b>June 12, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>May 22, 1967</b> , and that death occurred <b>before 8 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Gene U. Cohen, M.D.</b>				M.D. <b>GENE U. COHEN, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-12-67</b>									
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>1106 SPRING ST. SILVER SPRING, M.D.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Forest Glen, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>Wash. D.C.</b>				25. REC'D BY REGISTRAR <b>JUN 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 14 1967</b>							

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Francis J. Collins 3381 1st St. N.W. Wash. D.C. 20016  
Serial 100-100 St. John's Cemetery Forest Glen, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08411

08404

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna 833	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS 2423 Holt Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Ann Kelliher			4. DATE OF DEATH Month Day Year June 27 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 July 1962	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Connecticut	
13. FATHER'S NAME Daniel W. Kelliher			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No ---			17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014		
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Lymphocytic Leukemia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 48 Hours 2 Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 14, 19 67, to June 27, 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 27 19 67, and that death occurred at 2:15 M, from causes and on the date stated above.					
22a. SIGNATURE Joel J. Rubenstein		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 27 June 1967	
22c. PHYSICIAN'S NAME (Type) Joel J. Rubenstein, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-30-67	23c. NAME OF CEMETERY OR CREMATORY Clarence Fillmore		23d. LOCATION (City or Town) (County) (State) Clarence, New York (Erie Co.)	
24. FUNERAL DIRECTOR Money & King, 171 W. Maple Ave. Vienna, Va.		25a. REC'D BY REGISTRAR DATE JUN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED OF BIRTH

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>9 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4301 Dunnell Lane</u>				d. STREET ADDRESS <u>4301 DUNNELL Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>JOSEPH</u> Last <u>KRIZ</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 16, 1907</u>	9. AGE (In years last birthday) <u>60 yrs.</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIO ENGINEERS WTOP</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOSEPH KRIZ</u>				14. MOTHER'S MAIDEN NAME <u>MARIE MASINDA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-8924</u>		17. INFORMANT Address <u>Mrs. Edna Kriz 4301 Dunnell Lane KENSINGTON MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE PROSTATE.</u> DUE TO (b) <u>WITH METASTASES.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>OVER 6 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>(Type 1, 1967)</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>61</u> , to <u>May 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Hugo G. Graziani, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>				22d. ADDRESS <u>10101 GEORGIA AVE, SILVER SP., MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 6-3-1967</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince Georges Co. Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 7 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-6000

00100

STATE OF TEXAS

31133

1000

1000

THE STATE OF TEXAS, COUNTY OF DALLAS, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

WITNESSED my hand and the seal of the County of Dallas, this 10th day of May, 1960.

CLERK OF THE COUNTY OF DALLAS

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08413 Item #2c & d Film #9389 6/19/67 pc 08406											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville/ Bethesda, Md. 20034</u> d. STREET ADDRESS <u>9205 Adlaide Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First Middle Last				4. DATE OF DEATH <u>LAMPE</u> Month Day Year <u>June 8 19 67</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 1 1896</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ashmore</u>						14. MOTHER'S MAIDEN NAME <u>Charlotte Love</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u>				17. ADDRESS <u>Mrs. Dorothy L. Flynn 9205 Adlaide Ct. Beth. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 days</u>											
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from <u>1966</u> to <u>8 June 1967</u> , that (2) (we) last saw the deceased alive on <u>5 June 1967</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>SEREE S. DAUM</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>8 June 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>SEREE S. DAUM</u>				22d. ADDRESS <u>4977 Battery Lane Bethesda Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cloverleaf Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Woodbridge N.J.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. DeWee</u>				ADDRESS <u>Washington D.C.</u>				25a. REC'D BY REGISTRAR <u>JUN 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08108

08113

JUN 14 1961

Washington D.C.

James A. Baker

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08409

08414

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY in lb <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. STREET ADDRESS <u>10019 Lorain Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Grace</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>87</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julian Hemmersloagh</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-62760</u>	
17. INFORMANT <u>5006 E. Inner Ave Baltimore Md</u> <u>Son. Harvey H. London</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Generalized</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Fracture of Left Hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS <u>Contributing</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in street when shopping</u>	
20c. TIME OF INJURY Hour <u>7:30</u> p.m. Month, Day, Year <u>April 21 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Silver Spring Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>6/10/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda Md</u>	
23a. BURIAL, CREMATION, EMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City or town) (County) (State) <u>Pikesville Balt. Md</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 15 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08415

08410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>4502 Maple Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Laughlin</u> Middle <u>Laughlin</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>11-3-89</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Laughlin</u>		14. MOTHER'S MAIDEN NAME <u>Martha Flegin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>578-03-7643</u>	
17. INFORMANT <u>Bartholomew McCulliffe</u>		Address <u>4618 Rasedale</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> DUE TO (b) <u>Hypertension Arteriosclerosis</u> DUE TO (c) <u>Cerebral-Cardio-Vascular Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1967</u> , to <u>June 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>7-20 1967</u> , and that death occurred at <u>6:15 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>P.P. Andrews</u>		22b. DATE SIGNED <u>6-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS M.D.</u>		22d. ADDRESS <u>WASHINGTON, D.C. 20016</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1511 Rockville Pike</u> <u>Rockville, Md.</u>		25. REC'D BY REGISTRAR <u>JUN 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #2c, 17 & 21 Film #G390 6/30/67 pc

08416

CERTIFICATE OF DEATH

08411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN lb <u>31 days</u>		d. STREET ADDRESS <u>5805 Ringfield Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carrie</u>		DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/80</u>
9. AGE (In years) <u>86</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Westmoreland Co. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Reed</u>		14. MOTHER'S MAIDEN NAME <u>Louise Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-60-1885</u>	
17. INFORMANT <u>Carolyn</u> Address <u>Some address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vasc. Accident</u> 331X DUE TO (b) <u>Enterovirus</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-22-1967</u> to <u>6-21-1967</u> that (I) (we) last saw the deceased alive on <u>6-21-1967</u> , and that death occurred at <u>7:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. Wm. F. Luckett</u>		22b. DATE SIGNED <u>6-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wm. F. Luckett</u>		22d. ADDRESS <u>5000 Reno Road, N.W. Wash. DC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-24-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Paulk's Son - Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1811

DEPARTMENT OF DEATH

D.C.

Washington, D.C.  
August 18/80

8/1/80

7/1/80

Washington, D.C.

Charles F. Smith

222 W. 12th St.

W.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08417

CERTIFICATE OF DEATH

08412

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp</u>			d. STREET ADDRESS <u>12807 Flack St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dorothy Marie Leahy</u>			4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2/2/1912</u>		9. AGE (In years lost birthday) yrs. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home-Maker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany Missouri</u>	
13. FATHER'S NAME <u>Victor Laciney</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Cirrhosis of the liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>6-1</u> , 19 <u>67</u> , to <u>6-8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>67</u> , and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>R. H. Sandstrom</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom</u>		22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/12/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES COUNTY, MD.</u>	
24. FUNERAL DIRECTOR <u>HYONG'S FUNERAL HOME</u>		ADDRESS <u>1300-N. STREET, N.W. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS

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## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR + 6 mo</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. STREET ADDRESS <b>9802 LORRAINE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY HOBURG LEE</b>		4. DATE OF DEATH Month Day Year <b>JUNE 28 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-21-1892</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Redeemed Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>EASTON - MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>WILLIAM THOMAS LEE</b>	
14. MOTHER'S MAIDEN NAME <b>EMMA OREGON ROBERTS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-50-1047</b>		17. INFORMANT <b>Hoburg Lee</b> Address <b>6305 Landon Lane Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>28 June 1967</b> , that (I) (we) last saw the deceased alive on <b>27 June 1967</b> , and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William D. And</b>		22b. DATE SIGNED <b>6/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D. And</b>		22d. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>Thomas Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>11/15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b>	

VR A15 (4)  
20 M 1/66

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08413					08413				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY <b>Montgomery</b> MARYLAND					a. STATE <b>D.C.</b> b. COUNTY — — —				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>#6 Hesketh Street,</b>					d. STREET ADDRESS <b>3139 19th Street, N.W.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <b>Bertram Gorman Lennon</b>					Month Day Year <b>JUNE 13 1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-10-1893</b>		9. AGE (In years last birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>James F. Lennon</b>					14. MOTHER'S MAIDEN NAME <b>Gorman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>678-54-2886</b>				
17. INFORMANT <b>Mrs. Patricia Lennon Richards</b>					Address <b>8611 Burning Tree Road, Bethesda, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barcinoma ileocecal region with pulmonary metastases</b> 1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 23, 1966</b> to <b>June 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1967</b> , and that death occurred at <b>8:02</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert N. Coale</b>					22b. DATE SIGNED <b>June 13, 1967</b>				
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>					22d. ADDRESS <b>4429 Bradley Lane, Chevy Chase, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>6-17-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc. Wash. D.C.</b>					25a. REC'D BY REGISTRAR <b>JUN 19 1967</b>				
					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08420 CERTIFICATE OF DEATH 08414

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Hodges Lane</u>		d. STREET ADDRESS <u>105 Hodges Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>HEWLETT</u> Last <u>LEWIS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul-10, 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ephraim Hewlett</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Potter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>240-10-4567</u>	
17. INFORMANT <u>Mrs. Leary L. Waters (same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>5 years</u> <u>10 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>  </u> to <u>6/1/67</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>1 May</u> 19 <u>67</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M.B. Queen</u>		22b. DATE SIGNED <u>6/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.B. QUEEN</u>		22d. ADDRESS <u>344 University Blvd. W Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Winter Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Winter Park, North Carolina</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Waters, 254 Carroll St NW, Wash DC</u>		25. REC'D BY REGISTRAR <u>JUN 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08421

CERTIFICATE OF DEATH

08408

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Bethesda		c. LENGTH OF STAY IN 1b 9 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last William C. LINDSEY		4. DATE OF DEATH Month Day Year Jun 30 1967		
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1898	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy (retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Ashville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Thomas LINDSEY		14. MOTHER'S MAIDEN NAME Elizabeth (unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes unknown		16. SOCIAL SECURITY NO. unknown		
17. INFORMANT Frances LINDSEY		Address 6851 N.W. 19th Court Hollywood, Florida		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 21 Jun, 1967, to 30 Jun, 1967, that (x) (we) last saw the deceased alive on 30 Jun 1967, and that death occurred at 1020P M, from causes and on the date stated above.				
22a. SIGNATURE B.M. Onofrio		22b. DATE SIGNED 2 Jul 1967		
22c. PHYSICIAN'S NAME (Type) B.M. ONOFRIO		22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVE (Specify) Cremation	23b. DATE THEREOF 7/5/67	23c. NAME OF CEMETERY OR CREMATORY Grove Park	23d. LOCATION (City or Town) (County) (State) Miami Fla.	
24. FUNERAL DIRECTOR W.W. CHAMBERS, 1400 Chapin St., N.W. Washington, D.C.		25. REC'D BY REGISTER JUL 6 1967 DATE		
25. REGISTRAR'S SIGNATURE John A. Juge				

13 18

UNITED STATES OF AMERICA

1931

Name		Address		City		State		County		Zip	
John Doe		123 Main St		New York		NY		NY		10001	
Age		Sex		Marital Status		Occupation		Education		Religion	
35		Male		Single		Engineer		High School		Protestant	
Date of Birth		Date of Marriage		Date of Arrival		Date of Departure		Date of Return		Date of Stay	
01-01-1900		01-01-1920		01-01-1930		01-01-1931		01-01-1932		01-01-1933	
Place of Birth		Place of Marriage		Place of Arrival		Place of Departure		Place of Return		Place of Stay	
New York		New York		New York		New York		New York		New York	
Country of Birth		Country of Marriage		Country of Arrival		Country of Departure		Country of Return		Country of Stay	
USA		USA		USA		USA		USA		USA	
Date of Entry		Date of Exit		Date of Re-entry		Date of Re-exit		Date of Re-entry		Date of Re-exit	
01-01-1931		01-01-1932		01-01-1933		01-01-1934		01-01-1935		01-01-1936	
Signature		Signature		Signature		Signature		Signature		Signature	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
Date		Date		Date		Date		Date		Date	
01-01-1931		01-01-1932		01-01-1933		01-01-1934		01-01-1935		01-01-1936	
Place		Place		Place		Place		Place		Place	
New York		New York		New York		New York		New York		New York	
Country		Country		Country		Country		Country		Country	
USA		USA		USA		USA		USA		USA	
Date of Stay		Date of Stay		Date of Stay		Date of Stay		Date of Stay		Date of Stay	
01-01-1931		01-01-1932		01-01-1933		01-01-1934		01-01-1935		01-01-1936	
Place of Stay		Place of Stay		Place of Stay		Place of Stay		Place of Stay		Place of Stay	
New York		New York		New York		New York		New York		New York	
Country of Stay		Country of Stay		Country of Stay		Country of Stay		Country of Stay		Country of Stay	
USA		USA		USA		USA		USA		USA	

08422

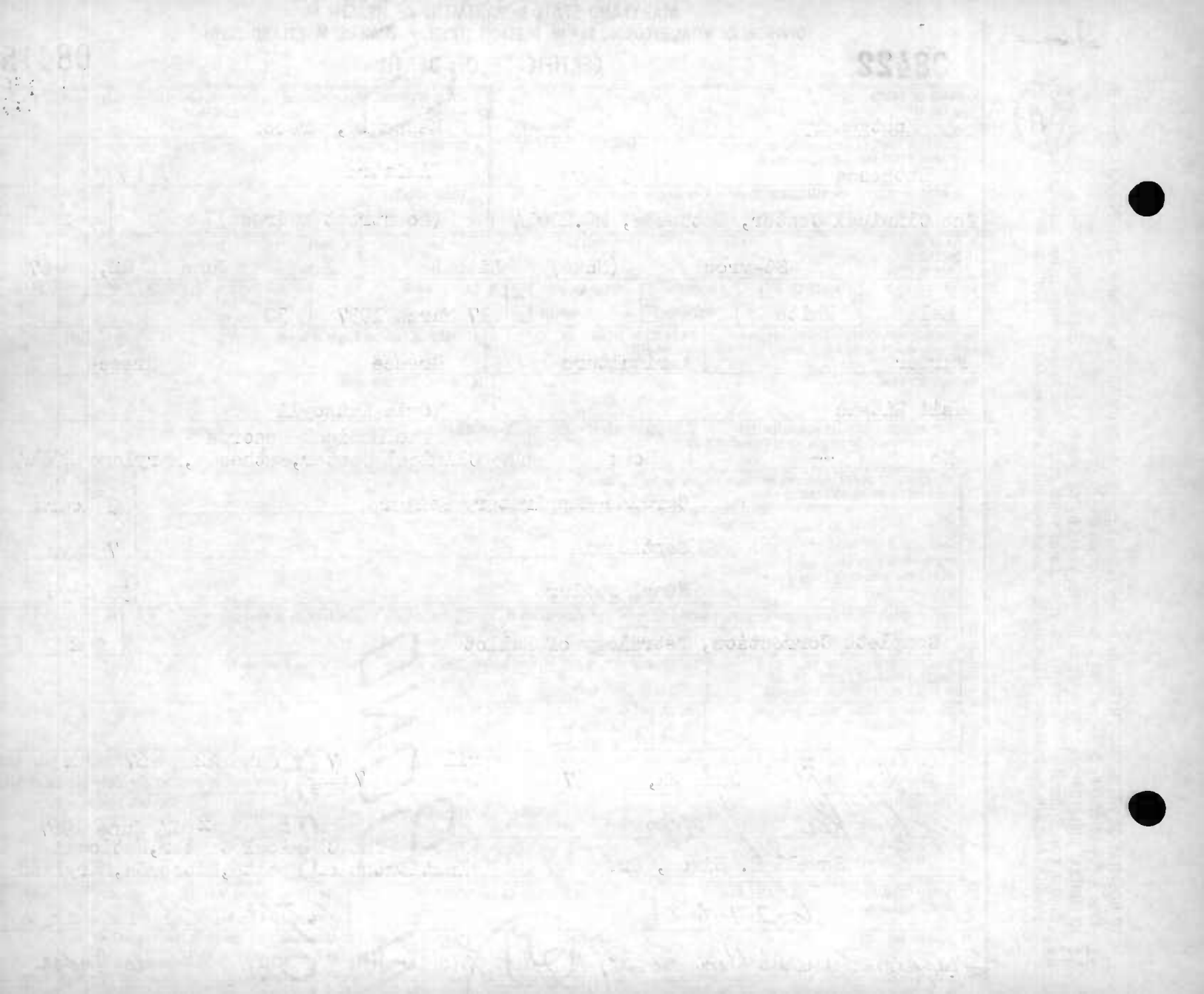
## CERTIFICATE OF DEATH

08415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>69 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, MD.20014</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Messenia, Greece</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Filiatra</u> d. STREET ADDRESS <u>(No street address)</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stavros (None) Litsas</u>		4. DATE OF DEATH Month Day Year <u>June 22, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 March 1937</u>
9. AGE (In years lost birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>22</u> <u>15</u> <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Basil Litsas</u>		14. MOTHER'S MAIDEN NAME <u>Toyla Katsoyli</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Failure</u> DUE TO <u>7540</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> DUE TO (c) <u>Renal Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>7 days</u> <u>30 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete Correction, Tetralogy of Fallot</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>April 14, 1967</u> , to <u>June 22, 1967</u> , that <u>he</u> (we) last saw the deceased alive on <u>June 22, 1967</u> , and that death occurred at <u>7:22PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>24 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sewell H. Dixon, Jr.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-27-67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <u>Athens Greece</u>
24. FUNERAL DIRECTOR <u>Frazier's Funeral Home Inc. 389-R. D. Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>DE</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
25c. DATE <u>JUN 28 1967</u>		25d. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Items 1-21 Film 390  
7-13-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08416

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. &amp; HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN DOUGLAS LIVINGSTON</u>		4. DATE OF DEATH <u>JUNE 5 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-94</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>	
13. FATHER'S NAME <u>LINDLY LIVINGSTON</u>		14. MOTHER'S MAIDEN NAME <u>ROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. MABLE LIVINGSTON - WIFE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple extreme internal injuries</u> DUE TO (b) <u>due to fall</u> DUE TO (c) <u>902.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, pruning tree, fell 40 ft. to ground.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5 45 p.m. 6-5 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Backyard</u>		20f. (City or town) (County) (State) <u>Takoma Park Montg Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Yeap</u> M.D.		22. DATE SIGNED <u>June 6, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. YEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash Cemetery, Riggs Rd &amp; Res. Rd.</u>	23d. LOCATION (City or town) (County) (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. DEC'D BY REGISTRAR <u>254 Carroll St</u> DATE <u>JUN 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

00123

00123

Received of the  
Treasurer of the  
Board of Directors  
the sum of \$100.00  
for the purpose of  
the purchase of  
the stock of the  
company.

This receipt is  
valid for the  
purpose of the  
purchase of the  
stock of the  
company.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08424

08417

<b>PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN <u>39 days</u>		d. STREET ADDRESS <u>5607 PARKSTONE Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MIRERVA M. LUKE</u>		4. DATE OF DEATH Month Day Year <u>6-14-1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/99</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ROBARGE</u>		14. MOTHER'S MAIDEN NAME <u>BELINDA DUANE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-62-4096</u>	
17. INFORMANT <u>CHARLES O. LUKE - See Item No. 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1909</u> IMMEDIATE CAUSE (a) <u>Melanoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>6/14</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>6/13</u> , 19 <u>67</u> , and that death occurred at <u>6:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>6/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Leonard Gold</u>		22d. ADDRESS <u>8641 Cloesville Rd. Silver Sp. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-17-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pulaski Cemetery Assn. Pulaski, N.Y.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>5150 Wisc. Ave. N.W. Wash. D.C.</u>	

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